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TRANSACTIONS

OF THE

TWENTY-FOURTH ANNUAL SESSION,

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

HELD AT PHILADELPHIA, SEPT. 18-20, 1888.

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1889.

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To the Homœopathic Medical Society of the State of Pennsylvania:

The Proceedings and Papers of the Twenty-Fourth Annual Session are hereby respectfully submitted:

CLARENCE BARTLETT, M.D.,
J. F. COOPER, M.D.,
J. H. CLOSSON, M.D.,

Committee on Publication.

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In Memoriam.

W. R. CHILDS, M.D.

One of the Members of this Society who aided in its organization, in 1866; its President at the Twentieth Annual Session, held at Pittsburgh, in 1884; and, at the time of his death, its Necrologist.

BORN—FEBRUARY 18, 1833.
DIED—NOVEMBER 11, 1888.

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CONTENTS.

	PAGE
Calling to Order,	9
Address of Welcome. W. H. Bigler, M.D.,	9
President's Annual Address,	10
Report of the Treasurer,	25
Report of the Auditing Committee,	25
Report of the Corresponding Secretary,	26
Report of the Committee on Publication,	27
Report of the Bureau of Organization, Registration and Statistics,	28
Necrological Report,	30
Report of the Board of Censors,	34
REPORT OF THE BUREAU OF PÆDOLOGY:	34
Poliomyelitis Anterior Acuta. Margaret L. Crumpton, M.D.,	35
Chorea. S. F. Shannon, M.D.,	37
Constipation in Infants. J. Richey Horner, M.D.,	43
Tinea Tonsurans. J. H. Closson, M.D.,	48
Baby Therapeutics. Z. T. Miller, M.D.,	341
REPORT OF THE BUREAU OF SANITARY SCIENCE:	58
The Sanitary System of Pennsylvania; Its Merits and Defects. Pemberton Dudley, M.D.,	59
REPORT OF THE BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY. Horace F. Ivins, M.D.,	65
Errors of Refraction and the Use and Abuse of Spectacles. W. H. Bigler, M.D.,	65
Foreign Bodies in the Ear, and their Extraction. Joseph E. Jones, M.D.,	71
Three Cases of Papillomata of the Larynx. Horace F. Ivins, M.D.,	78
Hay-Fever. The Allegheny County Society,	85
Tinnitus Aurium. W. H. H. Neville, M.D.,	90
Discussion,	94
REPORT OF THE BUREAU OF OBSTETRICS:	97
The Character of the Pulse after Labor. Joseph M. Reeves, M.D.,	98
Prolapsus of the Umbilical Cord. W. J. Martin, M.D.,	101
Discussion,	109
REPORT OF THE BUREAU OF MATERIA MEDICA:	116
Arsenicum Album. The Farrington Club of Pittsburgh,	117
Provings of Zincum Picricum. Charles Mohr, M.D.,	206
REPORT OF THE BUREAU OF GYNÆCOLOGY:	213
Erosions of the Os Uteri. Millie J. Chapman, M.D.,	213
Cervical Endometritis. T. M. Bulick, M.D.,	216
Vaginismus. J. W. Thatcher, M.D.,	219
The Influence of Gonorrhœal Infection on the Development of Pelvic Diseases in Women. B. F. Betts, M.D.,	222

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PAGE

REPORT OF THE BUREAU OF PÆDOLOGY AND PATHOLOGY: 227
Anatomical Lesions in Inveterate Intermittent Fever. John C. Morgan, M.D., ... 227
Neoplasms and their Genesis. W. K. Ingersoll, M.D., . . . 237
The Pathology of Renal Calculi. Joseph Rodes, M.D., . . 242

REPORT OF THE BUREAU OF CLINICAL MEDICINE: 250
The Effects of Tobacco on the Heart. E. R. Snader, M.D., . . 251
Clinical Cases. W. A. Haman, M.D., ... 260
Discussion, ... 266
Clinical Cases. Sarah J. Coe, M.D., ... 267
Discussion, ... 271
Chronic Gastric Catarrh. E. C. Parsons, M.D., ... 273
Auxiliary Treatment of Simple Cardiac Hypertrophy. E. R. Snader, M.D., ... 282
A Case of Carcinoma of the Breast v. *Erysipelas and Arsenic,* Charles Mohr, M.D , ... 289
Unsuccessful Clinical Experience. Z. T. Miller, M.D., . . . 292
Some General Remarks on Blood-Letting. G. Maxwell Christine, M.D., ... 298
Discussion, ... 308
A Case of Pulmonary Tuberculosis and the Results of One Dose of Calcarea Carb. 50,000, ... 310
Pulmonary Phthisis. W. C. Goodno, M.D., ... 313
Discussion, ... 320
Why Early Homœopathy was Successful in the Treatment of Syphilis. W. B. Trites, M.D., ... 324
Staphisagria for the Relief of Mercurial Eczema Z. T. Miller, M.D., ... 331
Balsam of Copaiva; An Experiment. Edward Cranch, M.D., . 341

REPORT OF BUREAU OF SURGERY: 341
Surgical Cases. W. R. Childs, M.D., ... 342
Remarks on the Antiseptic Treatment of Carbuncle and Kindred Inflammations. W. B. Van Lennep, M.D., ... 346
Discussion, ... 353
Surgical Cases. Charles Gangloff, M.D., ... 359
General Business, ... 362
Report of Committee on President's Address, ... 364
Election of Officers, ... 366
Appointment of Bureaus and Committees, ... 366
Adjournment, ... 368
Constitution and By-Laws, ... 369
List of Members, ... 377
Index, ... 387

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PROCEEDINGS

OF THE

TWENTY-FOURTH ANNUAL SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

PHILADELPHIA, September 18th, 19th, and 20th, 1888.

THE Twenty-fourth Annual session of the Homœopathic Medical Society of the State of Pennsylvania was called to order at 10.30 A.M., September 18th, 1888, by the President, Dr. Hugh Pitcairn, of Harrisburg. Dr. Wm. H. Bigler, President of the Philadelphia County Society, then delivered the following address of welcome on behalf of the County Society:

MR. PRESIDENT AND FELLOW MEMBERS OF THE PENNSYLVANIA STATE SOCIETY:

It becomes my pleasing duty, as President of the Philadelphia County Society, in the name and in behalf of the profession of this city, to extend to you a cordial welcome.

I have always thought that an address of welcome should be short, and from my present standpoint I am more firmly convinced of it than ever.

The days are past when it was felt to be necessary to draw the attention of visitors to the beauties and advantages of our

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City of Brotherly Love. We need no longer chant the praises of our ambitious Public Buildings, of our hard-worked Mint, of our much-frequented Park, of our well-meaning streets, and of our nourishing Schuylkill water: their merits are known and approved by all. We, therefore, merely present you figuratively with the keys of our city, and trust that you will feel at home among us.

But it is not only to the city that we would welcome you, but particularly to these halls, in the prosperity of which all physicians who have the true welfare of Homœopathy at heart must take a special interest. She who is the Alma Mater of so many of you, and the sister, or the cousin, or the aunt of the Alma Maters of the rest, bids you welcome after a two years' separation, and points with pardonable pride to the evidences of her healthy vigor, and continued growth.

We trust that this meeting of our Society may prove of benefit to each individual member by furnishing him with the stimulus of new ideas, and the confirmation of old ones, and that it may serve to strengthen the bonds of mutual friendship and esteem that should unite us all as members of one noble profession, and we hope that when we separate, it may be with the conviction on your part that our welcome of to-day, if short, was heartfelt and sincere.

The President, Dr. Pitcairn, then responded on behalf of the visiting members, after which he delivered the

PRESIDENT'S ANNUAL ADDRESS.

MEMBERS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA:

Another year, with its successes and failures, its privileges availed of and its opportunities neglected, has passed into the account which we must all meet when our life's work has been accomplished, and we stand before "The Great Physician" who knows neither school of medicine nor sect in the art of healing, but who, by his own example, commands us to go comfort and heal by *every* means within our command.

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Hahnemann, in his inimitable *Organon*, says: "The physician's highest and only calling is to restore health to the sick." "The highest aim of healing is the speedy, gentle, and permanent restoration of health, or alleviation of disease in its ENTIRE *extent*, in the shortest, most reliable, and safest manner."

Whatever we may credit further of his writings, more than the law of similars which he gave us, we can all stand firmly and unitedly on these bases. How well we have this year thus performed our different duty we may only know here in part, but cannot know fully; so it behooves us not to be too hasty in our conclusions, or too quick in our condemnations; neither should we say complacently, "Are not Abana and Pharpar .... better than all the waters of Israel?" We must familiarize ourselves with, and investigate all things pertaining to therapeutic science, holding fast only that which is good.

During the year, some who have shared with us these responsible privileges, and according to their opportunities, in their day, have served humanity well, have been called to their reward, while we are brought together again to utter our experiences, compare notes, and thus be prepared for better results in the year opening upon us. Notably among those who have passed away are:

William M. Zerns, M.D., of Philadelphia, September 21st, 1887.

John K. Lee, M.D., of Philadelphia, November 10th, 1887.

Percy O. B. Gause, M.D., Aiken, South Carolina, November 10th, 1887.

Adolph Lippe, of Philadelphia, January 23d, 1888.

I was peculiarly and forcibly impressed with these interrogative sentences of the address of Professor A. R. Thomas, last year, at our Pittsburgh meeting:

"Does homœopathy constitute the whole of therapeutic science?" "Is the physician best prepared to cope with disease in its varied forms whose knowledge and use of drugs is always, and only, confined to their homœopathic use?" "Has the physician discharged his full duty to his patients, in all cases, when he has made the most careful selections of the symptoms in the case?" "May the medical school, in view of its responsibility in the education of physicians, confine its therapeutic teachings

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to the homœopathic medication alone?" And, without wishing to antagonize the peculiar views of any member of our State Society, I am constrained to affirm negatively to every proposition.

One of the elements that contributed to the phenomenal success of homœopathic practitioners of medicine in the past, has been the fact that, while believing firmly in the fundamental theories enunciated by Hahnemann, yet they were broad-minded investigators of truth from every source, and learned in ALL the wisdom of THE SCHOOLS. They were thus twice armed, having a knowledge of what might have been done in each case by practitioners who preceded them; enabled thus to counteract evil from drugging, etc., and, at the same time, having a knowledge of what could be accomplished with better means; while "our friends the enemy" (determined at least in their own minds to be considered such) utterly refused to investigate the bulwark of strength we possess in our "Law of Cure." Indeed, the one thing, in my intercourse with educated allopathic practitioners of medicine in our day, that has most amazed me, has been the utter want of even a slight knowledge of homœopathic laws and theories—or, indeed, any therapeutic practice outside of their sect; for surely, if there be a sect in medicine, it is the so-called "Regular" sect.

I come before you to-day, therefore, to plead for greater latitude in our own professional intercourse with each other, in all matters doubtful or bearing the semblance of doubt, believing, as I do, that the greatest evil in therapeutic medicine in the past has been the adoption of creeds and codes, with ostracism of those who thought for themselves.

What might the "Allopathic sect" not have accomplished in the past hundred years, had they patiently, without prejudice, investigated Hahnemann's discoveries, availing themselves of the truth first formulated by him and his coadjutors? Yea, what suffering and misery might humanity have escaped? Surely, "There are none so blind as they who will not see." I say again, the great evil in the past in medicine, no less than in theology, has been in the adoption of "creeds."

There is something of art and science in medicine, but as in

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chemistry, botany, astronomy, and all the arts and sciences, there is an ever-widening, expanding, increasing range of discovery and improvement. What would be thought of a creed in astronomy with fixed codes? There are laws in medicine, "natural laws," too, which we recognize, as, for instance, the benign law of similars, with others allied thereto, but these are not all there is of law. Rules and principles we recognize, but they are open to change and improvement, as more facts are gathered and generalized. Is there anything absolutely fixed? We may to-day be impressed by a law of nature, supreme in its own sphere, but can we say that there are no other laws in other spheres of the science and art of healing?

We must not, therefore, dogmatize or form creeds, thus subjecting ourselves to the ridicule of an intelligent public, but we should hold that all that has preceded in our theories and practices may be altered or amended in accordance with increasing light and the evolutions of general science; *fortunately these have thus far only served to make more luminous and effulgent the fundamental principles of homœopathy.*

It is not to be wondered at that the allopathic school chafe under the effect of the name given us in reproach, on thrusting us out from their sect; it is a good name, a synonym for the words progress and liberality, and we are reminded by "THE WORD" that a good name is rather to be chosen than great riches. The name certainly has brought us patients, and *patience* brings riches and contentment if we grow not weary in well-doing.

The bigotry formerly so commonly manifested toward homœopathy is happily passing away, and must do so completely if we but enlighten the public as to the advantages of its therapeutic results.

Let us hereafter try to sink some of our selfishness for the public good, and, though we are all busy men, devote at least a small portion of our time to the public enlightenment.

In Pennsylvania, homœopathic practitioners of medicine minister to fully one-fourth of the entire population of the State, who desire to be under our care or desire homœopathic treatment for themselves and their dear ones. *This vast number of*

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citizens are without any representation in the charities of the State, which is indeed a gross outrage upon us and upon our constituency—and the fact that a sect in medicine has controlled the millions of *money* appropriated from year to year forms an establishment more galling than the church establishment of Great Britain or any other country.

It is for you to discuss how we may enlighten the public and our lawmakers, as to the beneficent laws of our school and attainments of our practitioners as well as to successful therapeutic results, and thus compel proper recognition of our rights. Our motto should be "Equal Taxation, Equal Representation."

For years we have been calmly resolving that there should be an effort made to have one or more of Pennsylvania's State asylums for the insane, placed under homœopathic therapeutic charge, but we never seem to realize the fact that to accomplish this desideratum, we must show the general public the justice of our claim to recognition. The present accommodations for the insane of the State, we learn from the Board of Public Charities, are inadequate, and we believe that the State Executive, as well as many other of our public officials, would favor the placing of a new asylum under the charge of our school, but why should we be compelled to wait such indefinite consummation when our claim is one so manifestly urgent and just?

To this end I have prepared comparative tables showing the results of the treatment in the different insane asylums and institutions of the States of Pennsylvania, Massachusetts, New York, Michigan, etc.,—under allopathic and homœopathic control—as well as other statistical information bearing on the same general subject.

The laws of our Commonwealth, recognizing no establishment in church or sect, should shake off this last remnant of class legislation bequeathed to us by the old world, and compel all those who practice the art of healing to investigate and apply ALL truth available wherever found, especially should it be an effort in our own colleges not to confine our therapeutic teachings to our own school methods only, but avail ourselves of everything known; first, for the cure where possible, and sec-

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ondly, for the relief, when only this can be obtained for suffering humanity. It is because of the recognition of this divine principle of helpfulness by all means, that we have been enabled to accomplish such wonderful results in private practice and in public institutions.

I herewith present a summary of statistics for the five years ending September 30th, 1887, of the following asylums.

Harrisburg, Pa. (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	576	39	6.77	139	24	4.16
1884	526	36	6.84	65	23	4.37
1885	564	45	7.97	89	27	4.78
1886	575	50	8.69	64	20	3.47
1887	611	44	7.20	70	31	5.07

Average percentage of deaths for five years, ... 7.49
" " recoveries " 4.37

Norristown, Pa. (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	1371	123	8.97	238	101	7.36
1884	1366	96	7.	156	92	6.73
1885	1730	125	7.22	185	98	5.66
1886	1847	127	6.87	224	105	5.68
1887	1964	155	7.89	136	76	3.86

Average percentage of deaths for five years, ... 7.59
" " recoveries " 5.85

Danville, Pa. (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	395	16	4.	52	19	4.81
1884	528	29	5.49	87	37	7.
1885	859	41	4.77	72	41	4.77
1886	996	49	4.91	101	40	4.
1887	1054	52	4.93	208	45	4.26

Average percentage of deaths for five years, ... 4.82
" " recoveries " 4.96

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Dixmont, Pa. (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	661	53	8.	116	33	4.99
1884	687	69	10.	102	28	4.
1885	719	59	8.20	123	66	9.17
1886	742	43	5.79	112	53	7.14
1887	795	77	9.68	118	35	4.40

Average percentage of deaths for five years, ... 8.33
" " recoveries " 5.94

Warren, Pa. (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	540	34	6.29	83	34	6.29
1884	626	46	7.34	97	36	5.75
1885	782	58	7.41	101	29	3.70
1886	842	65	7.71	119	44	5.22
1887	880	67	7.61	155	51	5.79

Average percentage of deaths for five years, ... 7.27
" " recoveries " 5.35

Summary of Statistics for Five Years ending September 30th, 1887, for Harrisburg, Danville, Dixmont, Norristown, and Warren (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	3543	265	7.47	622	211	5.95
1884	3733	276	7.39	507	221	5.92
1885	4654	328	7.	576	261	5.60
1886	5002	334	6.67	620	262	5.23
1887	5304	395	7.44	687	238	4.48

Average percentage of deaths for five years, ... 7.19
" " recoveries " 5.43

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Utica, Buffalo, and Rochester, New York (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	2017	131	6.49	776	240	11.89
1884	2187	148	6.76	872	242	11.06
1885	2251	117	5.19	922	247	10.97
1886	2364	122	5.16	964	217	9.17
1887	2367	152	6.42	1014	283	11.91

Average percentage of deaths for five years, ... 6.00
" " recoveries " 11.00

Worcester and Northampton, Mass., Hospitals, and of Taunton and Danvers, Mass., Asylums (Old School).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	3551	240	6.75	1056	231	6.50
1884	3706	248	6.69	1198	259	6.98
1885	3764	247	6.56	1142	265	7.
1886	3945	228	5.77	1395	261	6.61
1887	3804	230	6.04	1318	224	5.88

Average percentage of deaths for five years, ... 6.36
" " recoveries " 6.59

Middletown, New York (Homœopathic).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1883	410	18	4.39	150	69	16.82
1884	423	21	4.96	141	68	16.07
1885	486	27	5.55	131	66	13.58
1886	568	17	2.99	157	80	14.08
1887	642	22	3.42	187	96	14.95

Average percentage of deaths for five years, ... 4.26
" " recoveries " 15.10

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Westborough, Mass. (Homœopathic).

Year.	Number Treated.	Died.	Percentage of Deaths.	Number Discharged.	Recovered.	Percentage of Recoveries.
1887	430	19	4.4	123	55	12.79

Average percentage of deaths, ... 4.4
" " recoveries, ... 12.79

I append also the following extract from the report of the Massachusetts State Board of Charities for the year 1887, the percentage of recoveries and the word homœopathic, after Westborough Hospital, being added by me:

[FROM REPORT OF STATE BOARD OF CHARITIES FOR 1887.]

"Among the 530 patients who have been admitted at Westborough in the past thirteen months nearly half have been transferred from the older hospitals, and more than two-thirds were chronic cases. . . . . Notwithstanding this fact the recoveries have been considerable, and the current cost no greater than it was natural to estimate for a new hospital managed by persons who had *not* before directed such an establishment.

"The Westborough Hospital has met with many difficulties in its first year, arising in part from the defective work done in fitting up the basement of the old school buildings, which have been made over into a very serviceable hospital, and partly from the inexperience of the managers, natural to a new establishment. The accidental introduction of diphtheria and its propagation (in some way not yet fully understood) increased those difficulties; but an examination of its results at the end of the present calendar year will probably show that it has been as successful as new hospitals usually are; and in some respects its record is very gratifying. The death-rate among its patients has been considerably less than that of most hospitals in the State, and even less than the death-rate at the Bridgewater Asylum, the patients for which were generally selected because of their good state of health, while the Westborough patients, in part, had been newly committed, and, therefore, were more likely to

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die in their first year than those removed from other hospitals. The figures of the death-rate, brought to the same standard of comparison, are approximately as follows, arranged in order downward from the highest to the lowest:

Hospitals.	Whole No.	Deaths.	Death rate.	Percentage of Recoveries.
Worcester Asylum	444	38	8.5	.....
Tewksbury Asylum	442	33	7.4	.....
Boston Hospital	330	22	6.7	.....
Danvers Hospital	1188	79	6.6	5.4
Taunton Hospital	934	39	6.3	6.3
Worcester Hospital	1057	61	5.8	7.
Bridgewater Asylum	155	8	5.1	.....
Northampton Hospital	633	31	4.9	4.2
Westborough Hospital (Homœopathic)	517	25*	4.8½	12.79

"The Westborough figures are the actual numbers for fifty-two weeks, instead of the forty-two weeks between December 7th and October 1st. The new hospital is lowest on the list, and has a death-rate but little more than three-fourths as great as that of the eight institutions above mentioned, when taken together, with their whole number of patients reduced to the actual aggregate of different persons therein residing during the year. This is a favorable showing, and it is to be hoped, though hardly expected, that the same low death-rate will be maintained in subsequent years."*

The following is a summary of the statistics for twenty-one months, from September 30th, 1886, to June 30th, 1888 (the Legislature having changed the end of the fiscal year from September 30th to June 30th) of the Asylum at Ionia, Michigan (Homœopathic).

Number of patients remaining September 30th, 1886,	95
Number of patients admitted during period to June 30th, 1888,	47
Total number treated,	142
Number of recoveries during period,	17
Per cent. of recoveries during period on whole number,	12
Per cent. of deaths for 12 months ending Sept. 30th, 1887,	2⅗
Per cent. of deaths for 9 months ending June 30th, 1888,	3⅗

* Let it be remembered that the above facts are part of the report of the Massachusetts State Board, and not my words.

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Most of these patients were chronics, hence the seeming low per cent. of cures, but the per cent. of cures of patients admitted during the period was 36 per cent.

DEDUCTIONS.

The percentage of deaths under old-school treatment in Pennsylvania as compared with old-school treatment in New York is one-seventh higher, while the percentage of recoveries in the five years is only one-half. Why so great a difference, if not because of the stimulating influence of the one homœopathic asylum at Middletown? *and why, in the name of humanity, should this large number of unfortunates be allowed to suffer on worse than death indefinitely, if even old-school treatment in New York could give the required help?*

But when we come to compare homœopathic supervision elsewhere with Pennsylvania institutions the contrast is simply amazing:

The percentage of deaths under allopathic treatment in Pennsylvania,	7 19
Middletown, New York (Homœopathic),	4.26
Westborough, Mass. (Homœopathic),	4.8*
Ionia, Michigan (Homœopathic),	$2\frac{3}{5}$ to $3\frac{3}{5}$

The percentage of recoveries under allopathic treatment in Pennsylvania shows the outrageously low average of almost *nil* (about five per cent.), while we have the wonderful record under homœopathic treatment at—

Middletown, New York,	15.10 per cent.
Westborough, Mass.,	12.79 "
Ionia, Michigan,	12.00 "
" " Patients admitted during year,	36.00 "

With such results, which school of medicine should be taunted with "*vis medicatrix naturæ*"? HOW MANY DID KINDLY NATURE CURE?—five per cent.? Surely our enlightened and humane lawmakers can no longer close their eyes to such figures—the naked statistics furnished by those who have in the past been in no way desirous of helping the cause of homœopathy.

* Actually 4.4.

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The State Board of Charities of Massachusetts admit (see part of their report above):

First. That our treatment could not show its best results because of an epidemic of diphtheria, defective plumbing, etc., and the large number of chronic cases shoved on the institution. The question naturally arises, what would have been the decrease in the death-rate, as well as increase in percentage of recoveries, had the treatment been untrammelled?

With regard to the Middletown Homœopathic Insane Asylum the same fact obtains—incurable chronic cases, not only from the other institutions of the State, *their worst cases*, but as well from Pennsylvania (for where is there a prominent homœopathic physician in this State who has not sent a patient to Middletown for homœopathic treatment, being unable to secure such in our own State?).

Allowance should, therefore, be made for these facts, which demonstrate that the homœopathic practice will, under favorable circumstances, cure four to one as compared with the treatment at present received in the old-school "*Insane hospitals*" of Pennsylvania. But these are not "Insane hospitals;" rather should they be christened "Houses of restraint," where the inmates are herded together awaiting only death or "*vis medicatrix naturæ*." Think of it! Only five out of every hundred insane persons may hope for cure. *Is there any science in old school medicine in Pennsylvania?*

There is also an economic side to this question of the treatment of the State's insane. In the treatment of other diseases there is the same or greater proportion of cases. Take the well-established test treatment of pneumonia. According to the records, the mortality was:

Under allopathic treatment,	. . . . .	20.5 per cent.
" non-interference treatment,	. . . . .	7.4 "
" homœopathic "	. . . . .	6 "

But this is not all. The duration of the disease was:

Under allopathic treatment,	. . . . .	31 days
" non-interference treatment,	. . . . .	28 "
" homœopathic "	. . . . .	12 "

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What would be the saving to the State of Pennsylvania for labor, hospital, and other expenses in public institutions with a change of management?

The following summary of statistics is from the Michigan State Prison. This prison has been changed several times from one school to the other. I give first three years under allopathic care, then three years under homœopathic care. The prison passed back into allopathic hands, and I give two years under allopathic care, followed by two years under homœopathic care:

	Average No. of Convicts per annum.	Total No. of deaths.	Total No. days labor lost.	Total cost of Hospital stores.
Allopathic care, 3 years.	435	39	23,000	$1678.00
Homœopathic care, 3 years	545	20	10,000	500.00
Allopathic, 2 years . .	Not known.	Not known	24,000	1800.00
Homœopathic, 2 years .	Not known.	Not known	11,000	900.00

I regret that I cannot give other figures I have seen in print, which, I think, would fully demonstrate *the fact* that half the total number of days' labor lost in State institutions, due to sickness, might be saved, at a reduced expense to one-third the present outlay for hospital stores, care, etc.

In the five years represented by the figures above given, the population of the insane hospitals of Pennsylvania has increased from thirty-five hundred to fifty-three hundred, a total increase of eighteen hundred, or one-third. At the same ratio of increase what will be done with these poor, unfortunate creatures five years hence? *The almshouses of the different counties are already overcrowded* with them, and these latter without even the shadow of medical supervision supposed to be given in so-called "Insane asylums."

It seems to me that, if each member of our State Society would properly present even these meagre statistics, with others at their command, to their constituencies and members of the Legislature, arousing indignation at the outrageous ostracism by "*the powers that be*" of so respectable a portion of taxpayers, it would not be many months until insane asylums, and appro-

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priations for hospitals in general, would be more equitably administered.

I would suggest the appointment of a bureau for the collection, collation, and promulgation of statistics from every source available, showing comparison of treatment, and that, if possible, a fund be secured to this end. We need not fear comparison. The old school have no figures with which they can meet those already in our possession.

It is a satisfaction to be able to report a general advance of our school throughout the State, and *yet there is room.* The field, already overcrowded by old-school practitioners, is only partly occupied by us. Not only in our own State, but everywhere, our cause is moving steadily forward in the improvement and establishing of hospitals, and the occupation of outlying districts by thoroughly educated and efficient PHYSICIANS, not Sectarians, who crowd out the old-school methods and practitioners with their antiquated procedures, causing an increase of the longevity of the race. How much of the marked increase in longevity of the present generation may be traced principally to the teachings and practice of homœopathy is an intensely interesting question.

It is also gratifying to be able to state that all homœopathic colleges east of the Ohio river require a three-years' course of *college* study before graduation is permitted, and that the American Institute of Homœopathy at its last meeting adopted a resolution requiring all the homœopathic colleges in the United States to adopt the three-years' course not later than 1891.

Very few of the allopathic colleges do more than *recommend* a three-years' course of college study.

PAPERS AND DISCUSSIONS.

Many papers of our State Society, prepared by our members at great expenditure of time and strength, in my estimation, do not accomplish the good justified by the outlay because of delay and method of publication. I would urge upon you the desirability of some action similar to that lately taken by the Ameri-

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can Institute of Homœopathy, to allow of their publication whenever desirable in the current literature of homœopathy, under certain restrictions. This society owes it to its general excellence, it being acknowledged as one of the best of our State societies, and should, therefore, take the lead of other societies in this direction for the general good.

I would require:

First. That all papers to be published outside of the TRANSACTIONS shall be furnished in duplicate, and *only* secured through the Secretary of the State Society.

Secondly. Restriction of number of papers furnished to any one periodical, to be two or less.

Thirdly. We might stipulate with each journal that publishes our papers that they shall carry an advertisement of one page, announcing the Table of Contents of our Society TRANSACTIONS, etc.

I would urge upon you the desirability of the discussion of each subject brought before our meeting, and for the sake of accuracy, etc., where remedies are mentioned, the potency used be always specified.

TIME AND PLACE OF MEETING.

It has been suggested that probably a change of the time of the meeting of this society to spring instead of fall, so as to take advantage of the time of meeting of the alumni associations and commencement exercises of colleges might prove advantageous in securing a larger attendance. I would advise a thorough consideration of this matter.

Ladies and gentlemen, allow me again to express to you my sincere thanks for the honor you conferred in electing me, so young a member of this Society, to preside at this time. I can only crave your indulgence if I should unintentionally err in fulfilling the duties of the office, and wish for each of you a very pleasant sojourn in Philadelphia, and a profitable session of the Society.

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Dr. Pemberton Dudley moved that a vote of thanks be extended to the President for his very able address, and that a committee consisting of seven members of the Society be appointed to take into consideration the subjects therein treated, and report later at this session. Unanimously adopted.

The Vice-President of the Society, Dr. W. B. Trites, appointed as the Committee on President's Address the following members: Pemberton Dudley, M.D., Horace F. Ivins, M.D., J. K. Lee, M.D., Jno. E. James, M.D., Joseph E. Jones, M.D., I. G. Smedley, M.D., and W. J. Martin, M.D.

Dr. J. F. Cooper, the Treasurer, presented the following report:

REPORT OF THE TREASURER.

To the Homœopathic Medical Society of Pennsylvania:

Received as dues of membership during the year, ...	$680 00	
Balance from report of last year, . .	18 90	
Proceeds of sale of Transactions, . .	46 00	
Owen & Co. over charge, ...	15	
		$745 05
Paid for the Society as per bills, . .	$636 53	
Balance in the hands of the Treasurer,	108 52	
		$745 05

J. F. Cooper, M.D.,
Treasurer.

On motion this report was accepted, and referred to the Auditing Committee. This committee consisted of the following members: Thos. S. Dunning, M.D., W. J. Martin, M.D., and I. G. Smedley, M.D.

REPORT OF THE AUDITING COMMITTEE.

The undersigned, Auditing Committee appointed by the Homœopathic Medical Society of the State of Pennsylvania,

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would respectfully report, that they have examined the accounts of the Treasurer and have found them correct.

Respectfully submitted,

THOS. S. DUNNING, M.D.,
W. J. MARTIN, M.D.,
I. G. SMEDLEY, M.D.,
Auditing Committee.

The report of the Corresponding Secretary was then presented.

REPORT OF THE CORRESPONDING SECRETARY.

To the Homœopathic Medical Society of the State of Pennsylvania:

During the last year there has been but little to transpire that requires to be called to your attention by your Corresponding Secretary. The Treasurer of the Society, Dr. J. F. Cooper, has suggested the advisability of changing the time of our meetings from the fall to the spring of the year. One argument that he brings forward in support of the change is that then our meetings can be held in connection with those of the Alumni Association of the Hahnemann Medical College. The combination of forces would thus add strength to the meetings. An additional advantage claimed for the change is that visitors from other States would be attracted to our meetings. Your Secretary in making his announcements to the profession of Pennsylvania cordially invited an expression of opinion from physicians non-resident of Philadelphia regarding the proposed change. Thus far he has heard no expression from any one outside of Philadelphia. In order that this subject may receive more consideration than can be given in open meeting, your Secretary would recommend that it be referred to a committee of members non-residents of Philadelphia, said committee to report on Thursday morning.

Reduced rates of railroad fare have again been secured for this meeting. The concession in rates does not amount to much, if anything, for those who live in towns adjacent to Philadelphia, but for those residing at the western end of the

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State it is important. Members residing near at hand hesitate to make use of the card-orders, not desiring to bother the Corresponding Secretary. This is a mistake. Every one who attends these sessions should make use of the card-orders whenever possible; it must be remembered that these orders will not be issued in future years unless a number satisfactory to the company are used by the members at this meeting.

Respectfully submitted,

CLARENCE BARTLETT, M.D.,
Corresponding Secretary.

On motion this report was accepted, and referred for action to the committee appointed to consider the matters contained in the President's address.

The report of the Committee on Publication was presented by the Corresponding Secretary.

REPORT OF THE COMMITTEE ON PUBLICATION.

To the Homœopathic Medical Society of the State of Pennsylvania:

Your Committee would report that the Transactions of the last Annual Session were issued in a volume of 370 pages, in style uniform with those of previous years. Three hundred and twenty-five copies were issued at a cost of $500.00. One hundred and thirty-five were sent to regular members, twelve to honorary members, and six to corresponding members, thirteen to colleges, twenty-two to journals, six to other State societies, and four were sold.

The esteem in which our Proceedings are held by the profession outside the State of Pennsylvania is gratifying in the extreme, although it does not result in our selling many copies of our Transactions. Reviewers invariably speak well of the work done by the Society, and do not hesitate to say that it is the best working Homœopathic society in the country; the enthusiasm of one journalist being so great as to make him say that the Pennsylvania State Society does better work than the American Institute. At the New York State Society meet-

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ing held last week in Syracuse, N. Y., a member made a motion looking to certain improvements in that Society, giving as a reason for his motion that the societies of Pennsylvania, Massachusetts, and Illinois were all doing better work than was that of New York.

Further testimony as to the value of our papers is to be found in the frequency with which they are copied from our Transactions in other States and even in foreign countries.

Respectfully submitted,

CLARENCE BARTLETT, M.D.,
J. H. CLOSSON, M.D.,
J. F. COOPER, M.D.,
Committee on Publication.

The report of the Bureau of Organization, Registration and Statistics was next presented.

REPORT OF THE BUREAU OF ORGANIZATION, REGISTRATION AND STATISTICS.

To the Homœopathic Medical Society of the State of Pennsylvania:

It gives your Committee pleasure to report the condition of our school in the State of Pennsylvania in a flourishing condition. As regards the number of homœopathic physicians in the State, there is some question. A directory in the hands of the Chairman of the Committee contains the number of 725. This directory, when published one year ago, gave us credit for but 575. Information received from the secretaries of the different county societies throughout the State, shows that this list is not complete, and that the number of physicians in Pennsylvania, practicing homœopathy openly, must be in the neighborhood of 900. Your Committee would suggest that the Committee of Organization, Registration and Statistics for the coming year assume the task of getting a complete list of the homœopathic physicians of the State. Work similar to this, should be undertaken by all the State societies throughout the country. It is customary for us to claim 10,000 physicians in the United States, yet search our directories as we will, we cannot find the names of more than 6500. From hearsay, we state that Ne-

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braska has over 400 homœopathic physicians, yet the medical directories give us only 150. The New York State Society is at present engaged in preparing a directory of the homœopathic physicians of that State.

There have been no new hospitals or dispensaries established since our last report, one year ago. The information given in our last report, that the Germantown Homœopathic Dispensary had been closed, was based on incorrect information given to the Chairman of this Bureau. This dispensary has been reorganized, and is now in a flourishing condition.

Three new societies have been added to the list since our last report. The first of these is the "Organon Club," of Chester; the second is the "Farrington Club," of Pittsburgh, an organization formed for the study of the materia medica; the third is the "Hahnemannian Clinical Society," of Philadelphia.

The Hahnemann Hospital of Philadelphia, which, at our last report, was closed, awaiting the erection of new buildings, has been reopened. An explanation respecting the report of this hospital, is here required. Of the 481 cases treated in the hospital during the past year, but 159 are reported as cured; 307 were relieved. Practically, all these cases should have been reported as cured, for they were made up entirely of accident-cases and operations. When they had improved sufficiently to leave the hospital, they were permitted to do so, and have the subsequent dressings carried on in the Surgical Department of the College Dispensary.

Our other charitable institutions throughout the State present favorable accounts of the work done during the year. The Homœopathic Hospital and Dispensary of Pittsburgh, The Children's Homœopathic Hospital of Philadelphia, the Women's Homœopathic General and Maternity Hospital and Dispensary, the Hahnemann College Dispensary and the Homœopathic Dispensaries of Allentown and Germantown, have, each, sent in reports of the work done by them.

Respectfully submitted,

CLARENCE BARTLETT, M.D.,
Chairman.

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In the absence of the Necrologist, Dr. W. R. Childs, of Pittsburgh, Dr. J. Richey Horner, of Allegheny, presented the Necrologist's Report, as follows:

NECROLOGICAL REPORT.

THE Report herewith presented, records the names of four of our membership, who have departed this life since the last report of your Necrologist was read. They are as follows: William M. Zerns, M.D., John K. Lee, M.D., Percy O. B. Gause, M.D., and Adolph Lippe, M.D.

This Society was holding its second day's session in Pittsburgh, last year—September 21st—when the protracted illness of Dr. William M. Zerns was brought to a close, and the angel of death bade him welcome to the great beyond. His death occurred at the residence of his wife's parents in Watertown, New York. He was aged thirty-five years.

DR. ZERNS was born in Salem County, N. J., studied medicine under the preceptorship of Dr. Aquilla Lippincott, of Salem, and received his degree from the Hahnemann College, Philadelphia, in 1873. He was a consistent member of the Society of Friends, a conscientious Christian gentleman, and a skilful and cultured physician. He was one of those who organized the Bœnninghausen Medical Club of Philadelphia, he also held membership in the County Medical Society, and has been an active member of this, our State Society since 1880.

The Bœnninghausen Medical Club published a series of resolutions, regarding this member's death, in the *Hahnemannian Monthly*.

JOHN K. LEE, A.M., M.D., was born in Allegheny County, Pa., May 2d, 1824. His parents emigrated to this country from England in 1814. After a thorough academic education, he entered Allegheny College at Meadville, Pa., in 1845, and was graduated in 1849, with the highest honors of the institution. Immediately on leaving college, he commenced the study of medicine in Philadelphia under the direction of Walter Williamson, M.D., and graduated at the Homœopathic Medical

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College of Pennsylvania, March 4th, 1851. He at once located in West Philadelphia, and made it his permanent home. In 1861, his *Alma Mater* elected him Professor of Materia Medica and Institutes of Medicine, which chair he filled with great ability for two years, when he was compelled to resign on account of the increasing demands of his professional duties. Dr. Lee was a member of the Philadelphia County Society, and was one of the founders of this, our State Society, serving as President in 1880. He exerted a most wholesome influence in the firm establishment of homœopathy in that portion of the city—a district noted for the culture and influence of its citizens—his high character, as a Christian gentleman, having secured him the personal friendship of many of the most distinguished citizens of the community in which he lived. For a long period—about thirty years—he held the position of Director of the Public Schools, and was warmly interested in their efficiency and prosperity. At one time he held the position of United States Pension Surgeon. About four years ago Governor Pattison appointed him a member of the State Board of Public Charities, a position of great responsibility, and demanding the exercise of the highest discretion. So well did he fulfil the requirements of this official post, that Governor Beaver reappointed him for the second term.

As a writer, Dr. Lee was forcible and pleasant. His valedictory to the graduating class of 1862, of the Homœopathic Medical College, on the doctrine of similitude, is a model of rugged truth, in easy diction. In personal appearance he was commanding; dignified in mien, and in conversation fluent and agreeable. He was a man entertaining the highest conceptions of public and private purity and integrity; he was eminently adapted to secure for himself and the profession he represented the highest measure of public confidence and esteem.

On the morning of November 10th, 1887, John K. Lee, A.M., M.D., was unexpectedly summoned from earth, after an illness of a few hours. On the previous evening he attended, as one of the specially invited guests, the tenth anniversary celebration of the Bœnninghausen Club, and sat at the dinner with his hosts until past midnight, though before leaving the banqueting-

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room, he complained of precordial pain and other discomforts. After reaching home, his symptoms grew worse, but were not of a character to alarm his family until a few minutes before his death which occurred at half past five o'clock. The autopsy revealed the cause of death to have been fatty degeneration of the heart.

PERCIVAL O. B. GAUSE, M.D.—After a lingering illness, Dr. "Percy" Gause, as he was familiarly known—the loved son of Professor O. B. Gause, M.D.—departed this life, on November 10th, 1887, at his parents' new home in Aiken, S. C., at the age of twenty-seven years. Born and educated in Philadelphia, he began the study of medicine under the preceptorship of his father, and, after graduating at the Hahnemann Medical College, he went to Europe, and spent a considerable period in the study of surgery and other applied branches in the Vienna and other hospitals. Shortly after his return, evidences of failing health began to be manifest, and these persisted, with some deceptive intervals of apparent improvement, until his decease. The nature of his malady was somewhat obscure, but every promise, held out by both medical and hygienic science, was tested, in the hope of preserving what, it was believed, would prove to be a most valuable professional life. Thus it came about that an unusually wide-spread professional interest was excited in behalf of young Dr. Gause's case, and, on all sides, his near friends were met with anxious inquiries and expressions of earnest hope for his recovery. This, however, was not to be, and shortly after the removal of the family to Aiken, S. C., the spirit took its departure. Professor Gause and his family will have the warm sympathy of many professional and lay friends in the loss of so estimable a son and brother; one in whose life there was bound up so much of promise and of hope. Dr. "Percy" became a member of this, our State Society, at the meeting held in Philadelphia in 1883.

ADOLPH LIPPE, M.D.—On the 11th of May, 1812, on the family estate of "Sée," near Gurletz, in Prussia, there was born, to Count Ludwig and Countess Augusta zur Lippe, a son, "Adolph, Graf zur Lippe, Weissenfield."

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Dr. Lippe was educated at Berlin. In 1839 he came to this country. He studied medicine at the Homœopathic College at Allentown, then the only one in this country, and on the 27th of July, 1841, received his diploma at the hands of the late Dr. Constantine Hering. He settled first in Pottsville, and subsequently in Carlisle, where he remained for six years, and then located permanently in Philadelphia. From 1863 to 1868, Dr. Lippe filled the Chair of Materia Medica, in the Homœopathic Medical College of Pennsylvania. Although always engaged in the busy work of a successful physician, he found time to employ his pen to contribute most copiously to the current literature of our school. His most useful public work is undoubtedly his *Text-Book of Materia Medica.* He was likewise instrumental in the establishment of several homœopathic journals; among them, the *Hahnemannian Monthly* and *Homœopathic Physician.*

The peculiar traits of Dr. Lippe's character which, of late years, kept him somewhat aloof from the mass of his professional brethren, we pass by, with the simple comment, that, doubtless, his intense dogmatism rested upon a basis of profound conviction, and was probably, in part at least, the result of early educational influences. It must not be forgotten that his first years of practice were spent amid the turmoils of clashing medical schools and systems, at a time when his opponents were making desperate attempts to throttle the infant system that he loved—a time which exacted from all the homœopathic physicians of that day a determined struggle for professional life. Such experiences are calculated to make men intolerant of opposition, either real or fancied. In estimating the worth of Dr. Lippe's life to his profession, we can well afford to forget everything save the service he rendered in the development of the materia medica and its clinical applications in the relief of sickness and suffering. All else will pass out of human recollection; *this* is destined to endure.

Dr. Lippe had not been in good health for some weeks; but having exposed himself during the raw and inclement weather of January, he contracted a bad cold which speedily developed into a violent attack of typhoid pneumonia, remedies were un-

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availing, and fifty-three hours after the attack was ushered in, death closed the scene—January 23d, 1888—in his seventy-sixth year. A widow and one son are left to mourn the death of a distinguished husband and father. This Society has enjoyed his membership for over twenty years.

W. R. CHILDS, M.D.,
Necrologist.

THE BOARD OF CENSORS, during the sessions, reported favorably on the following applications for membership; the candidates were accordingly elected:

JENNINGS, C. B., Reading,	Hahnemann Med. Col. of Phila.,	1881.
MERRIAM, FRANKLIN E., Philadelphia,	" " "	1888.
YOCUM, C. A., Pottstown,	" " "	1885.
MERCER, EDWARD W., Philadelphia,	" " "	1884.
SANDEL, J. H., Plymouth,	" " "	1882.
MCDOWELL, CHARLES H., Philadelphia,	" " "	1887.
CHISHOLM, H. C., Harrisburg,	" " "	1888.
MURDOCH, R., Wilkesbarre,	" " "	1872.
LAYMAN, ALFRED, Philadelphia,	" " "	1882.
READING, THOMAS, Pittsburgh,	" " "	1888.
HAWLEY, L. B., Phœnixville,	" " "	1853.
GRIFFITH, L. B., Philadelphia,	" " "	1880.
TONKIN, WILLIAM, Philadelphia,	" " "	1885.
CARMICHAEL, T. H., Philadelphia,	" " "	1886.
MERCER, C. S., Media,	" " "	1886.
MESSERVE, F. W., Philadelphia,	" " "	1885.
SULLIVAN, J. B., Allegheny,	Pulte Medical Col., Cincinnati,	1888.
JACKSON, W. H., Oil City,	Western Reserve University, Cleveland,	1868.
BURCHFIELD, S. E., Tarentum,	University of Michigan,	1881.
HARNER, John E., Honey Brook,	Cleveland Hom. Hosp. Coll.,	1882.

REPORT OF THE BUREAU OF PÆDOLOGY.

DR. J. K. LEE, of Johnstown, presented the Report of the Bureau of Pædology, which included the presentation of the following papers, which were accepted, and referred to the Committee on Publication:

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Polio-myelitis Anterior Acuta, by Margaret L. Crumpton, M.D.
Chorea, by S. F. Shannon, M.D.
Constipation in Infants, by J. Richey Horner, M.D.
Tinea Tonsurans, by James Harwood Closson, M.D.

POLIO-MYELITIS ANTERIOR ACUTA.

BY MARGARET L. CRUMPTON, M.D., ALLEGHENY, PA.

I HAVE had no experience in treating the disease, but this fact has not deterred me from writing about it. My limited acquaintance with medical conventions has taught me that the doctors who know the least often have the most to say. On such occasions it seems proper for a young doctor to atone for his lack of knowledge by the length of his paper. But I have deviated from this custom, having taken to heart the sage counsel of Samuel Weller in regard to "the great art of writing," to make 'em "wish there was more."

"Polio-myelitis is an acute inflammation of the anterior cornua of gray matter." It is sometimes called Infantile Spinal Paralysis. The disease is most common between one and four years of age, and generally makes its appearance in the summer or autumn. It sometimes follows an attack of febrile disease, is occasionally the result of mechanical injury, and often follows a chill during the period of teething.

Pathology.—The pathology of the disease shows an acute inflammation practically limited to the anterior horn, while in some cases the lateral column is involved. The lesion is more often confined to the lumbar and cervical enlargements. The multipolar nerve-cells which are the essential cells of this region, lose their functional activity, while some of the nerve-cells are dead, and the muscles become atrophied and paralyzed, but some of the cells are only impaired for a time. The deaths from this disease are so few, that the histological facts remain still a question, as only a small number of microscopical examinations have

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been made. All pathologists agree that the lesion is inflammatory, but whether the inflammation begins in the nerve-elements or in the connective tissue and bloodvessels is still a disputed point. The effect of the inflammatory process is destruction of the multipolar cells and atrophy of the axis cylinders. The process begins with hyperæmia and extravasation of red corpuscles. The leucocytes infiltrate the tissue so that it can be washed away under a gentle stream of water, which would have no effect upon the healthy structure. The tissues soon become brown on account of hæmoglobin changes. The cells of the neuroglia are filled with fat. Also the nerve-fibres and cells. The leucocytes take up the fat granules and form what is known as the corpuscles of Gluge.

Onset.—The onset is sudden; sometimes there is slight fever, and again the rise of temperature is more marked, and we have hot skin, quick pulse, muscular twitchings and mild delirium, but the fever stage is generally short. Then follow the paralytic symptoms which may occur in the night after a day of slight fever, and the motor impairment is at its height at once. The paralysis may be monoplegic or hemiplegic. Dr. Buzzard says that in some cases some of the muscles supplied by the medulla and pons are paralyzed. Prof. Remak has described different types in the upper extremity or the "upper arm type," in which the supinator longus, a muscle of the forearm, is affected along with the brachialis anticus, biceps, and deltoid, and a "forearm type," in which the supinator longus escapes, but the extensors of the wrist are affected, so that the paralysis affects muscles and parts of muscles which are related as to function. The muscles present the reaction of degeneration, the reflexes are lost or impaired. Sometimes there is pain and also a tenderness over the affected muscles, and the action of the sphincter muscles may be temporarily arrested. The termination of the disease is in incomplete recovery, the muscles remaining atrophied and paralyzed, and deformities, as club-foot, sometimes follow.

Diagnosis.—A positive diagnosis cannot be given until the paralysis sets in, as the onset may be mistaken for any febrile disease. But the fact that the paralysis reaches its highest de-

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gree at once is pathognomonic of the disease. In paralysis from reflex irritation the genito-urinary troubles will precede the paraplegia; in myelitis the urinary symptoms follow the paraplegia, and the urine is alkaline.

Treatment.—The treatment must be external and internal. Dr. O'Connor calls attention to the rubbing of the spine with cod-liver oil; to the frequent use of salt-water baths and massage. Charcot, Erb and others say that the nutrition of the paralyzed muscles can be maintained by electricity; the muscles which respond to the interrupted current should be faradized, and the others stimulated by the constant current. The diet should be light and nutritious, and the patient should avoid extremes of heat and cold. Remedies as acon., bell., ergot, plumbum, opium, and pinus sylvestris have been used with success.

CHOREA.

BY S. F. SHANNON, M.D., SEWICKLEY, PA.

CHOREA is a non-febrile convulsive disease, characterized by irregular and imperfectly co-ordinate, but not completely involuntary contractions of different parts of the muscular system and particularly of the muscles of the face and extremities. It is known by various other names, such as St. Vitus' dance, choreo-mania, and others. It is a disease of somewhat common occurrence, but, on account of its rarely being attended by fatal results, it is almost impossible to state what percentage of children have it, although many authors give the percentage as one-three-hundredth.

It rarely occurs during infant life, becomes more frequent in children up to ten years of age, and is most frequently met with in those between the ages of ten and fifteen years.

It is more frequently met with among girls than boys, and more frequently in girls of a delicate nervous temperament, who are approaching the age of puberty. Of the exciting causes

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the one most frequent and most clearly proven is the influence of the effects of terror.

Besides this cause may be mentioned irritation, blows or falls upon the head, prolonged excessive mental effort, fits of violent anger, and the difficult establishment of the menstrual function in girls, or the suppression of that function, or the suppression or drying up of ulcers or eruptions.

The disease may be general or partial, affecting all the muscular system, or only the muscles of certain parts of the body.

Frequently only one side of the body will be affected, or one arm of one side and a leg of the opposite side, or *vice versa.*

Among the prodromic symptoms may be mentioned irritability, loss of appetite, unusual degree of impressibility, languor, debility, disturbance of the organic functions, irregular state of the bowels, and, after a time, a certain quickness and irregularity of the movements.

Symptoms.—The movements are diversified and irregular; the limbs assume every attitude possible for them to assume; the fingers are opened and shut; brought together and separated with no regularity. The arms are pronated and supinated, the forearms flexed or extended upon the arm, and the movements are usually so rapid that the patient cannot retain anything in his hands.

At times there is such loss of will power that it is impossible for the patient even to feed himself.

The inferior extremities are affected like the superior ones. Walking is difficult or impossible; the patient totters from side to side, or walks quickly a short distance and then suddenly stops.

The child often falls when walking or running, either meeting with a slight obstruction or in consequence of imperfect muscular action.

The face is distorted into all conceivable shapes, sometimes being expressive of joy, at other times of sorrow, fear, or grief.

The mouth is opened and shut, and its corners, drawn apart, or to one or the other side. The tongue also participates in these sudden irregular movements.

The head is rapidly moved from side to side, backward or

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forward, or rotated. Sometimes it falls to one side, all control over the neck muscles being lost.

Frequently the muscles of the trunk are affected, rendering sitting on a chair or lying upon a bed impossible.

Deglutition is embarrassed, and sometimes there is heard a peculiar cry caused by spasm of the larynx.

The muscles of the heart are frequently affected, causing palpitation and irregular action of that organ.

There is usually no pain attendent upon the choreic movements, unless the disease be complicated, nor do the movements seem to be fatiguing to the little ones to any great degree.

The movements are increased by emotions, but are usually suspended entirely during sleep.

The intellect is rarely affected except in severe or long continued attacks.

The course of the disease is acute or chronic, although most frequently acute; the symptoms becoming more and more severe until they reach a climax, remain stationary for a time, and then gradually disappear.

Again, it may be the case that the symptoms become so severe as to require the placing of the patient in a straight jacket to prevent it from injuring itself; the patient deprived of rest becomes emaciated, respiration becomes difficult, the intelligence is abolished, the pupils contract, and the patient dies.

The duration of the disease is uncertain, varying from six weeks to more than as many months.

Relapses are common, and in some cases the symptoms are more severe than in the primary attack, or they may not be so severe.

The diagnosis is not difficult, as there is no disease simulating it.

The prognosis is generally favorable; unfavorable cases usually terminating in death from exhaustion due to prolonged and severe movements not permitting of rest.

Treatment.—Special attention should be paid to the state of the general health; a generous nourishing diet being advisable in patients who are run down, and especially among those who

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are found amongst the class of people where proper attention has not been paid to a strength-giving diet.

Great care must be exercised that the patient is not shocked or frightened, nor made sport of by his associates or playmates.

Moral treatment is vastly important. The child should never be startled by harsh or quickly spoken words, nor in any other manner.

He should be managed gently, but firmly and judiciously.

It may sometimes be advisable to use ether or chloroform inhalations to relieve the spasms.

Exercise should not be neglected, and, when deemed expedient, the child should be made to give a certain length of time each day to gymnastic movements.

Dr. Radcliffe says, "Each case of chorea must be looked upon from a special as well as from a general standpoint, and the success of treatment will in many instances depend upon the skill with which special means can be combined with those general means of which he speaks in Reynolds's System of Medicine."

Remedies.—To quote Radcliffe again, "Nothing can be more perplexing than the statements made by various authorities respecting the efficacy of remedial agents in the treatment of chorea. Indeed there is so little unanimity of opinion expressed regarding the treatment for chorea that the only course is for each one to *glance* at the principal remedial agents recommended, and then to assume the responsibility of deciding upon his own course of action."

Not so with the practitioners of homœopathy; there is no groping in the dark, nor glancing at the principal remedies recommended, but by careful inquiry and careful investigation the remedy will be found that will act and cure as thoroughly and quickly in this disease as it does in so many others.

Among the remedies of special importance in this disease may be mentioned the following: Agaricus, asafœtida, belladonna, causticum, china, cimicif., cina, crocus, cuprum, hyos., ignatia, iodine, kali brom., mygale, pulsatilla, rhus tox., secale, stramonium, sulphur, scutellaria, tarentula, zinc.

Agaricus.—True cerebral chorea, with clonic spasm when

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awake, quiet when asleep. Spasmodic motions from simple involuntary motions, and jerks of single muscles to a dancing of the whole body. Frequent nictitation of the eyelids, redness of the inner canthus, lachrymation, sensitiveness of the lumbar vertebræ, body greatly convulsed. Worse during approach of a thunderstorm. Itching spots on skin resembling chilblains.

Belladonna.—Especially after mental excitement; when the flexors are affected, and the paroxysms are preceded by a numb feeling in the muscles, or by a sensation as if a mouse ran over the extremities. Epidemic chorea. Flushed face and sore throat.

Calc. ost.—Twitching of the muscles, trembling of the whole body. Falling down. Great weariness. Chorea during second dentition, from onanism, or in leuco-phlegmatic persons when resulting from fright.

Causticum.—Convulsive movements, especially of right side. Eyes distended.

Cimicifuga rac.—This is one of the most frequently indicated remedies. It is most useful for cases of chorea occurring in patients of a rheumatic diathesis, those suffering from uterine irritation, and in cases resulting from physical causes.

The abnormal movements consist of twitching, jerking, and twisting motions, usually unilateral and confined to the left side, often attended by pains of a neuralgic or rheumatic nature. Depression of spirits and insomnia.

Cicuta virosa.—Twisting and distortion of the limbs, sometimes accompanied by screams; sudden rigidity with jerking of the limbs.

Cina.—The movements often commence with a shriek. The tongue, larynx, and œsophagus are affected, causing a clucking similar to that heard when pouring water from a bottle. Eyes staring; clean red tongue; pulse normal. In cases complicated with worms.

Crocus.—Spasmodic contraction of single sets of muscles, jumping, dancing, laughing, whistling. Worse usually in the evening. Changeable disposition.

Cuprum met.—Periodical chorea. Muscular contortions with laughter, grimaces, exaltation and ecstasies. Irregular move-

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ments commencing in fingers and toes. Twitchings are often confined to one side. Patients are better when lying.

Hyoscyamus.—Chorea the result or the consequence of long and debilitating diseases. Every muscle of the body twitches, and is thrown about, from the eyes to the toes. Great agitation and loquacity.

Ignatia.—Emotional chorea, especially from grief or fright, with sighing and sobbing. Attacks better when lying on the back, and usually better after eating.

Iodium.—Abdominal chorea, the stomach, liver, pancreas and abdominal glands being at fault.

Laurocerasus.—Emotional chorea, fearful contortions and jactitations when awake. Sleep restless. Unusual appetite. Indistinct speech, gets angry when not understood. Gasping for breath.

Mygale.—Facial muscles contorted. Arms and legs in constant motion. Unable to dress without assistance. Frontal headache, vertigo. Grating of the teeth at night. Worse in the morning.

Natrum mur.—Suitable for chronic cases after fright or suppression of facial eruptions. Jerks on the right side of the head. Paroxysms of jumping high up regardless of obstructions. Twitchings of the right side, worse at full moon (new moon—silica).

Opium.—Emotional cases. Cases arising from fright, shock, or fear. Arms are thrown out at right angles with the body. Spasmodic jerkings of the flexors.

Pulsatilla.—Cases occurring in young girls verging upon puberty, or in cases where the menstrual flow has been suppressed. With the customary *puls.* symptoms.

Nux vomica.—A remedy often indicated, and is required in cases when the child complains of vague flying pains about legs and chest, also a twitching of the jaws and upper extremities. Sensation of numbness in the affected muscles; unsteady gait; feet drag; movements renewed by the least touch, but lessened by steady pressure. Impaired appetite, constipation, despondency. Symptoms all worse in the early morning.

Secale corn.—Spasmodic twitchings, beginning in the facial

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muscles and spreading over the entire body. Convulsive starts, with the fingers spread out.

Sticta pulm.—Chorea complicated with hysteria, the movements are confined to the lower extremities. Evening aggravations. The feet and legs jump and dance about in spite of all efforts to prevent them. Sensation as if the legs were floating in the air when lying down.

Sumbul.—Constant jerking of head and limbs, protrusion of the tongue. Voracious appetite; happy disposition; expression idiotic; fear of becoming insane. Vomiting and constipation.

Valeriana.—Arms and legs move normally, but when at rest jerk and twitch. Agitation of all the nerves, jerks, twitches, trembling. Nervous, irritable dispositions.

Verat. vir.—Twitchings and contortions of the body, *unaffected* by sleep; froth about the lips; champing of the teeth; difficult swallowing; head jerking, or constantly nodding. Sexual excitement.

Zinc. met.—Twitchings in various muscles, the whole body jerks during sleep. Trembling of the hands. Depressed spirits; health suffers; feet fidgety, can't keep them still. The child is cross before the attack; the body is hot. Right side especially affected.

CONSTIPATION IN INFANTS.

BY J. RICHEY HORNER, M.D., ALLEGHENY, PA.

THE title of this paper might more properly be "The Prevention of Constipation in Infants," as it is the writer's desire to give a few suggestions as to how we may act so as to reduce to a minimum the number of this class of cases.

The true physician is he who goes beyond the treating of the case in hand. He aims to so treat his patients that the generations who are to follow may be freed as nearly as may be possible from any hereditary taint. He looks ahead—he takes into consideration the probable and possible results of his prescrip-

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tion as it may affect the distant future, and doing so he makes his prescription for the best good present and future.

Constipation is that condition in which there is prolonged retention of the fæces, or in which they are habitually expelled with difficulty or in insufficient quantity. In long-continued constipation, the intestinal contents are so retarded in their progress along the canal, that they undergo a too early and complete absorption of their fluid portions. In time, there occurs an accumulation and impaction of dry fæcal masses in the rectum, sigmoid flexure, descending or transverse colon, or cæcum. An obstacle is thus created, which may ultimately close the tube entirely and cause intestinal obstruction.

It is that form of constipation which we meet in early infancy that the writer wishes to discuss. It occurs at this age more frequently than at one year or over. In many cases, it is due to artificial feeding with condensed milk, cow's-milk, or the patent foods so largely used, in fact, to any diet which is unsuited to the digestive apparatus. Imperfect digestion of caseine, the filling of the bowel with a dry mass difficult to propel, and the consequent catarrhal state of the mucous membranes are causes of this trouble. Feeble, cachectic children with imperfect muscular development, and children born rachitic, scrofulous or syphilitic, are generally constipated.

Functional derangement of the liver, producing a deficiency in the secretion of bile, causes it; or the intestinal mucus may become deficient or too tenacious as in febrile conditions, or where the perspiration or urine is excessive.

Children who are very large and fat and sweat easily are more liable than those of medium weight and firm muscular development.

And just here comes the question of transmission of this tendency from mother to child. If the physician were more careful in his attention to the pregnant woman, she would have less trouble in the early months of the life of her child. We believe that Prof. H. N. Guernsey was right in his belief that an occasional dose of an anti-psoric remedy, whichever one that seems indicated, given to the woman during the last few months of her pregnancy would avert much trouble. We are sure that the

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majority of cases occur among the children of mothers who are habitually constipated.

There is another cause, and that is neglect on the part of the obstetrician. The first milk of the mother, the colostrum, is slightly cathartic, and has a slight though direct action on the liver. The caseine contained is different from that of the later milk, being much more readily assimilated. The physician who fails to take advantage of this wise provision on the part of nature is highly culpable.

Of many other causes, the different artificial foods are the most prolific.

Malformations of the bowel, either congenital or acquired, are not considered, as they belong to the province of the surgeon.

Of symptoms it is not necessary to speak much. The simple fact of the lack of normally frequent evacuations is enough for diagnosis. Of course there will arise, as a result of this, many other symptoms, loss of appetite, colicky pains, restless and disturbed sleep, etc. The fæces are hard, dry and of a light color, being passed with much difficulty. The abdomen is generally tympanitic, though it may be soft and flattened, in which latter case the hard masses may be felt in the descending and transverse colon. The tympanites may be so excessive as to displace the liver by pushing it upward. There may be eructations of gas or even vomiting, by which a temporary relief is afforded.

The remedies to be thought of are not many. But, though the writer has not as yet advanced to the position of a "high potency man," he believes that in this trouble the remedy should as a rule be given certainly not lower than the thirtieth and preferably in the two-hundredth. Then, too, a single dose should be administered and allowed to exhaust its action. The following list of remedies and indications for their use are taken almost *verbatim* from an article on this same subject written by Clarence M. Conant, M.D., New York, and published in vol. xv., page 203, of the *Transactions of the New York State Society* for 1879.

Alumina.—Stool is usually soft, and of light color; and, though the child does not cry as if in pain, still it grunts and strains, and seems to make a great effort to void this soft evacuation. This

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drug is especially valuable in long-standing cases which have resisted other drugs and in those which have been neglected.

Bryonia.—Stool is very dark as if burnt, and of large size; the mouth and lips are very dry; the child drinks often and copiously if allowed to do so; it is very irritable, and cries easily in an angry and violent manner. Like nux vomica this drug is useful after cathartics have been used freely, and especially after castor oil.

Calcarea carb.—Constipation during or from approach of dentition; stools of light color, hard and dry, looking like clay; scrofulous or fleshy children with poorly developed bones, and dry scald head.

Lycopodium.—Much flatulency, worse from four to eight P.M.; stool hard and dry, and evacuated with much straining; red sand in the urine; child cries while and after urinating, as well as during and after stool.

Nux vomica.—After cathartic medicines the child is very irritable, and has much colic; the stool is dry, hard and infrequent, or else frequent and scanty, and discharged with much pain and urging. When the nursing mother is of sedentary habit, and uses coffee and highly seasoned food, and the child very restless and sleepless.

Opium.—The stools occur in hard round black balls. There is perfect inertia of the bowels.

Sulphur.—The child has many eruptions and skin affections, especially excoriation of the anus and adjacent parts; other drugs fail.

Crocus sat.—Venous complications; hæmorrhagic diathesis.

Euphrasia.—The child has weak, red eyes, and a constant watery discharge from them and the nose; much colic, hard scanty stool.

Graphites.—The stool is of uncommonly large size and infrequent; the child is disposed to moist eruptions on various parts which exude a transparent, gluey discharge.

Hydrastis.—A remedy characterized by Hughes as being far superior to nux vomica. There are excoriations on or about the anus. It may be used locally in the 1st trituration prepared with corn-starch instead of milk-sugar and dusted on the parts.

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Apart from the medicinal treatment the regimenal is very important. This may be divided into that which is preventive, and that which is curative.

Take care of the pregnant woman. As noted before, give her some anti-psoric treatment. Look out for her habits of life, her diet and her surroundings. All this will have its effect on the child. You cannot expect the intestinal tract of a newly-born infant to be free from defect when the mother has been suffering from an obstinate and prolonged constipation.

Send your woman out into the open air. Give her a varied diet—fruits, vegetables, lemonade, water and milk. Put her on a course of oat-meal; depend on these measures rather than on the use of any of the mineral waters which are used so extensively on account of their laxative effect. Do not allow her to eat indiscriminately; have her select her diet carefully. Do not allow her much coffee. Better none at all.

If the constipation be due to mechanical pressure, you may relieve this, at least in a measure, by abdominal support, relieve the abdomen as much as possible of the weight of clothing.

Labor accomplished, comes the question of putting the child to the breast.

This colostrum, spoken of above, is intended to relieve the liver of its congested condition to clear out the bowels. There is very seldom a case in which it would be justifiable to deny the system of the child this relief. Even if the physical condition of the mother is such as to preclude the possibility of her nursing the child to and through dentition, she should nurse it for a few days, and then, if necessary, it may be weaned. But by all means give the child the benefit of the relief it can get from the colostrum, and do not wait too long—three to six hours—just as soon as the mother has had a little time to recover from the shock of the labor.

Again, it is known that some cases of constipation date back to an attack of jaundice. This also may be prevented. We believe it to be a good plan if the child is vigorous to allow the cord to bleed before tying it. In this way we can get a thorough drainage of the now-to-be-obliterated bloodvessels, and

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avoid hepatic plethora. Follow this course, and you will seldom have a case of either jaundice or constipation.

Another thing is cold water. Give the child some to drink; it is a tonic to the digestive tract. Every day give it a teaspoonful of cold water to drink, and, by the way, you may often quiet a crying baby by simply giving it a teaspoonful of cold water.

Give it oat-meal water. Put the meal—the medium grade—in cold water, boil this thoroughly, strain. Of this, give say four teaspoonfuls, four times a day.

We may sometimes get good results from rubbing the abdomen with olive oil.

Give the child plenty of out-door air and sunlight. Every baby over a month old should be out of doors most of the time—only excessive cold or dampness should prevent this while the child is well.

Of course, during all this time if the bowels do not move, we may afford temporary relief by small enemata of warm water or flaxseed water. Take two tablespoonfuls of the whole seed; put this into a muslin bag. Boil this in a pint and a half of water for fifteen minutes, cool to 100°, and give as injection a sufficient quantity. Repeat this each second morning, if necessary.

Meanwhile, if the mother be nursing her child, take her under your care. Watch her diet. Restrict her in those articles of food which tend to cause torpidity of the system.

TINEA TONSURANS.

BY JAMES HARWOOD CLOSSON, M.D., GERMANTOWN, PHILADA.

HAVING observed the progress of a number of cases of tinea tonsurans during the past three years, in hospital, dispensary, and private practice, I have thought the observations of sufficient value to the profession to make record of them, particularly so as the disease ranks among the most obstinate disorders

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to which children are subject, many of the cases coming under our notice proving very rebellious to treatment.

The disease is of a decidedly contagious character, the growth being greatly favored by a weakly constitution, the want of cleanliness, and some atmospheric changes more than others.

By the term "tinea tonsurans" is understood an affection of the scalp dependent upon the growth of a peculiar fungus, the trichophyton tonsurans, tinea being the generic term for the parasitic affections of the surface; it is a disease of the hair, and must be essentially and primarily caused by the growth of the fungus, since the characteristic effects are never produced without such growth.

By some, the disease is supposed to be due to a deranged state of health, originating in the organs of secretion, the vegetation being considered a secondary product; but it is a fact acknowledged by all that the disease cannot exist without the presence of this parasitic growth.

It is principally a disease of early life, occurring among the infants and children, but seldom among adults; the only cases in which it manifests itself in the latter being persons engaged in waiting upon or nursing children affected with the disease, it not being uncommon to find it involving the arms and hands while the disease of the scalp is seldom if ever met with.

The affection is characterized by the appearance upon the scalp of one or more circular or irregularly-shaped, variously-sized, scaly, more or less bald patches, showing the hair to be diseased, and usually broken off close to the scalp, in some cases apparently deprived in part or wholly of hair, then patches, erythematous at first, may be minutely papulo-vesicular, or vesicular about the periphery, and increasing by peripheral growth, may average two inches in diameter; these typical patches are accompanied by more or less itching, are circumscribed, slightly elevated, reddish, grayish-blue, or slate-colored, the color varying with the complexion of the individual; there is also more or less scaling, usually thin and bran-like in character.

The hairs are early involved, becoming lustreless, dry, brittle, twisted, and when broken off close to the scalp their free extremities are ragged and uneven, presenting a gnawed appearance;

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a variable degree of baldness occurs, which, however, is rarely permanent.

Tinea tonsurans is a chronic disease and may occur among the rich as well as the poor, but most frequently in children under twelve years of age; the most intractable symptoms of the disease are those dependent upon the changes effected by the plant in the hairs, and the parts concerned in their formation, the fungus invading the epidermis, hair follicle, bulb and shaft; the hair follicle becomes distended and raised, and the hairs being permeated with fungi, are disintegrated and destroyed.

The patches which form, may remain separate or may coalesce, thus forming irregular areas, the most favorite localities being the vertex and parietal regions, although any portion of the scalp may be invaded.

In all diseases like the tinea, in which the fungus is never absent, we can certainly give the parasite the most prominent place in the pathology of the disease; and, while regarding it as the determining cause, it is but reasonable to admit constitutional and local conditions as the predisposing causes, for a certain soil is requisite for the growth of the tinea vegetation, and that furnished by the debilitated diathesis is the necessary one.

While admitting that fungi are the undoubted cause of the lesions of the hair and epithelium, peculiar to the tonsurans, we must not forget that the disease will not flourish on healthy surfaces, and that those who are attacked always assimilate very tardily, and are generally deficient in fatty matter.

The growth of the disease is greatly favored by a weakly constitution, and the want of cleanliness; some atmospheric conditions more than others also favor its propagation, heat and moisture being favoring elements; thus it is, that after the long-continued use of moist compresses, especially when they have not been kept very clean and pure, do we sometimes find the beginning of an attack.

The peculiar parasite, the trichophyton, is, as has been said, the essential cause of the disease, and the mode of its propagation is chiefly by contagion, the scrofulous or debilitated constitution influencing the production of the disease by favoring the more ready growth of the parasite.

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Filthiness of every kind is most certainly a predisposing cause; age, also, exercises a marked influence upon the production of the disease, it being confined to children and early youth, most commonly occurring between the ages of three and twelve years.

The disease is probably most frequently met with in children's Homes and Asylums, at times affecting a large proportion of the inmates, being communicated by caps, combs, brushes, and towels; here, however, we find the proper soil for the attacks of the disease, as these children are most frequently of a lymphatic temperament—children who have been in the habit of taking very little fatty matter with their food, or, if taking it, assimilating it badly.

The secretion of the hair follicles, in some children, is also more favorable to the growth of the plant than in others, for, while the affection is exceedingly contagious—the most so of any of the phyto-parasitic diseases of the skin—yet it will not occur to every one exposed to the contagion, strumous children being much more liable than the healthy.

As a rule, there is no difficulty in recognizing the disease; the presence of the stumps of hair with gnawed appearance, prominent follicles, more or less baldness, slight or decided scaliness, roundish patches, are phenomena not found in any other disease, and render it easily distinguishable from any other eruption of the scalp; particularly in the early and advancing stages little or no difficulty should be experienced in the diagnosis, as the appearances will be sufficiently characteristic; even in the most difficult cases the microscopical appearance of the hairs will be sufficient to determine the diagnosis and give positive information.

The disease is not wholly restricted to the poor, but may be found in every rank of society, occurring on the body or limbs as well as on the hairy scalp, but is most difficult of cure when it attacks the latter.

Observation tends to show that the growth of the trichophyton may produce tinea versicolor, and well-authenticated cases have been cited in which the comunication could be traced directly to the scalp of infants at the breast affected with tinea tonsurans.

Cases have been reported where irritation has produced secre-

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tion in the disease, and a tinea favus crust formed; some authorities believe, however, that favus and tonsurans are but different stages of the same disease, but this is by no means the accepted theory.

Sycosis parasitic may also be produced from this disease. I remember treating a little girl affected with well-marked tinea tonsurans; an elder brother subsequently had sycosis parasitic, evidently the result of contact with the child.

Herpes circinatus parasitic may also give rise to tinea tonsurans, and *vice versa.* A young lad applied for treatment at the Germantown dispensary, troubled with herpes circinatus parasitic, of the cheek; subsequently, his brother presented himself with tinea tonsurans, all the naked-eye and minute appearances being present.

Spontaneous cure seldom takes place, the disease when left to itself tending to run on indefinitely; the ultimate result, however, if unchecked by treatment, will be the involvement of the entire scalp, with destruction of the hair follicles and therefore permanent loss of hair.

The following cases may be accepted as types of the aggravated form, after the disease has persisted for a long time; it will also be well to state that, in the Homes wherein these cases originated, the majority of the children present unquestionable signs of the strumous diathesis, a condition of the constitution, as has been before stated, rendering the disease decidedly more severe and obstinate.

CASE I.—Rebecca M., æt. 8 years. Admitted to the Children's Homœopathic Hospital, of Philadelphia, February 23, 1887, from one of the Homes for children which are so numerous in this city. She was troubled with two little erythematous patches on the left side of the head, which soon became covered with furfuraceous scales; these patches increased circumferentially while apparently healing in the centre, leaving the skin more or less rough; a crop of minute vesicles appeared on the patches, followed by desquamation; the diseased surface became slightly thickened and raised, bluish in color, and covered with fine, dry scales which were easily rubbed off; the hairs were altered, being unnaturally brittle, dull, dry, bent, twisted, and broken off; the

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hair follicles were prominent, and with all, a hereditary tendency to tuberculosis. These conditions persisted, with various fluctuations, for about eleven weeks, the patient being discharged cured March 8, 1887. In this case a great deal of attention was devoted to the digestive organs in order that cod-liver oil might be taken and retained, along with meat and milk diet; plenty of fresh air also proved very beneficial, in conjunction with extreme cleanliness; applications of the oleate of copper were principally relied upon, locally, and sepia internally.

CASE II.—Robert N., æt. 9 years. Admitted to the wards of the Children's Hospital, April 15, 1886, from a Home for Children. Small punctate vesicles, with clear contents, were arranged in a circular form on the back of the head, the patches being about one inch in diameter; these vesicles would dry shortly after their appearance, leaving small thin scales and crusts; new vesicles were continually forming in the immediate neighborhood, thus giving rise to new patches; the hairs were falling out or breaking off in circumscribed spots, the scalp becoming covered with scabs or crusts, which could be easily brushed off; the hair was lustreless and brittle, without its usual elasticity, and filamentous at the point of fracture; the fungus could be detected, not alone between the cells and the epidermis, but also in the hairs and the root-sheaths; the cervical glands were enlarged on both sides. In this case, the hairs of the entire scalp were shaved off; after which there was no chance for any diseased area, no matter how small, to escape observation; the scalp was frequently washed with tar-soap in order to get rid of the detached epidermis and masses of the fungus growth which were present in the form of minute scales; this case was very rebellious to treatment, and after lasting for some time, epilation became necessary, and while requiring great patience and considerable time, I am sure it was not nearly so painful as might be supposed; local applications of the oleate of copper were found to be directly useful in softening the epidermis, removing the secretions, and at the same time destroying the parasite; the curative effects of these local applications, however, are dependent somewhat on the state of the general health, as the persons attacked by the disease usually assimilate very tardily, and are

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generally deficient in fatty matter; this was particularly attended to in the treatment of this case, a large amount of fatty matter being given as food, and in the form of cod-liver oil; the internal remedy being sepia. This treatment was continued with ultimate success, the patient being discharged cured October 7, 1886.

CASE III.—Willie K., æt. 6 years. Admitted to the Children's Hospital, May 29, 1887. The disease had existed for a long time prior to his admission. On certain portions of the head the hair presented the appearance of having been nibbled off about one-eighth of an inch from the scalp; the hairs were broken, and were shorter, thicker, and more dull than the healthy; some of these were twisted, some bent at an angle; the patches were more or less circular in outline, and varying in size; the skin was altered in color, being of a slaty hue; the hair follicles were prominent and encircled with fine white scales; there was a slight elevation of the patches, which increased in size, fusing together until nearly the whole scalp was involved; there was also a certain amount of itching, especially worse when in bed. Before the little patient had been admitted to the hospital, many forms of treatment had been tried, but none with more than temporary success; it was, indeed, a most difficult case to cure, particularly as the disease had gained so very much headway; and, even while under our own care, premature suspension of treatment was followed by a recurrence of the disease; ultimately, however, appropriate and persistent treatment effected the cure. Cleanliness, in this case, was found to be of the utmost importance, the entire scalp being frequently bathed with warm water and tar-soap, and remedial applications of the oleate of copper used twice daily. Cod-liver oil was freely administered, and sepia given continuously; the patient being discharged October 9, 1887.

CASE IV.—Walter C., æt. 8 years, applied for treatment at the dispensary of the Children's Hospital, service of Dr. Thomas S. Dunning. There was a small red spot on the right side of the head, which gradually extended in circumference, producing a circular patch, covered with minute branny scales, with raised edges, the patch being about one inch in diameter; the hair falling off in the locality, left the scalp a little rougher and darker in color than the surrounding parts; some of the hairs were

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broken off short, with thickened stumps; the scalp was in a rough, harsh condition, the hair follicles prominent, considerable itching, and, upon close inspection, the apparently bald portion of the scalp was found in reality to be covered with innumerable short hair stumps projecting just a trifle above the surface. The local application in this case, as in the others, was oleate of copper. The main difficulty in the treatment of tinea tonsurans is to bring the locally applied remedy into contact with the fungus, but in this case, applied in the incipiency, but little difficulty was experienced. Cod-liver oil was used with very apparent benefit. The constitutional remedy was arsenicum iodatum. A little sister of the patient, æt. 5 years, was also similarly affected, and applied for treatment about the same time. The method of treatment adopted, however, effected a cure in each case in a little over a month.

CASE V.—Sadie A., æt. 6 years, was brought to me for treatment, September 12, 1887, with the following history: Intolerable itching on the left side of the scalp, particularly after retiring for the night. Upon close examination detected a slight eruption, circular in outline, pustular with a hair projecting from each pustule; a slightly changed condition of the hair, making it a reddish-yellow instead of its former light color, dull in appearance, dry, brittle, and in some places broken off a few lines from the scalp; subsequently followed a branny-like desquamation; there were two patches of about an inch and a quarter in diameter each, upon which the broken hairs did not resemble the closely-clipped, healthy hairs of the same length, but had rather a gnawed appearance, which was very peculiar; the extremities of these stubbles of hair were very brush-like, due to the splitting up of the shaft and the separation of the fibre by the spores of the trichophyton; these apparently nibbled hairs were lustreless, and of lighter color than the neighboring normal hair; there also seemed to be a very marked sense of dryness and constriction about the scalp, this I found to be very much lessened by the use of glycerine. After cutting the hair closely, and thoroughly washing with tar-soap and drying, an ointment of the oleate of copper was rubbed into the whole scalp; this was done regularly, night and morning, a cap or

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turban being worn to keep any of the preparation off the face and from soiling the bed-clothing. Much attention was paid to the general health and constitutional treatment of the patient. Good air, good food, and marked cleanliness, aided in the starvation of the parasite, and when the soil in which it grew and flourished could no longer nourish it, the eruption gradually disappeared and the hair resumed its healthy growth. Sepia was the internal remedy employed. The treatment above described, including the oleate of copper, was continued for a fortnight after the eruption had entirely disappeared in order to avoid any possibility of a relapse, the last prescription being made December 14, 1887.

An opinion regarding the length of time required to cure tinea tonsurans should always be guarded; for, while some cases respond to treatment in several weeks, in others several months and even more may be required.

The treatment of the disease is very tedious, and the chief indication, the principle which underlies the treatment, is to destroy the parasitic plant; so long as the fungus is external it can readily be reached; but it most frequently extends down into the walls of the hair follicles, and attacks the epidermis, the hair bulbs, and that portion of the hair within the sac; hence, the length of time required to cure the disease is due to the impossibility of getting parasiticides to the bottom of the hair follicles in which the fungus has embedded itself; in the most aggravated of these cases it becomes necessary to get away as much of the fungus as possible, and that by the extraction of the hair.

Next to this carefully performed epilation, probably in these severe cases, the best treatment is to use an application that will keep up a slight degree of congestion to the affected skin for a considerable period of time, this will give rise, undoubtedly, to a persistent effusion of serum, which will penetrate the hair sheaths, and bathe unceasingly the spores that surround and infiltrate the hair, and, finally, act destructively on the fungus.

Strict attention to cleanliness is in all cases most important, not only with a view of hastening the cure but also of prevent-

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ing contagion, and for this purpose frequent baths with tar soap should be recommended; the patient should also be provided with special wearing apparel, combs, brushes, towels, bed-linen, etc.

Proper attention should be given to the condition of the various secretions and functions of the body as well as to the constitutional and other dyscrasiæ, upon which the proper selection of the remedy is always more or less dependent.

External remedies should never be relied upon exclusively, for nearly always a condition of malnutrition exists, and proper food, fresh air, and suitable internal medication is required.

In the treatment the main indication is to get rid of the parasite; the hair must, therefore, be cropped off closely by means of hair clippers, or, preferably, shaved. This will at once show the contrast between the upright and shining hair of health with the underlying healthy scalp, and the dull, brittle, twisted, bent, and broken-off hair and the scaly and inflamed scalp of disease.

The attempt should always be made to destroy the fungus germs by the use of some parasiticide application; the following, having aided in accomplishing the cure in the cases previously quoted, is here given as the most preferable application to apply locally:

℞. Oleate of copper, ... ʒj.
Vaseline, ... ʒiv.

The above, to accomplish that for which it is intended, should be used twice daily, in the morning, after the head has been carefully cleaned and washed with the lather of tar and soap, and again at night. Should the scalp be rough and harsh, a few nightly applications of glycerine or sweet-oil will soften it materially.

It should be remembered that even in the most carefully treated cases some of the fungus elements may be left behind in the follicles, and growing up into the hair-shaft lead to the disorganization of the hair; in these cases, which are by no

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means infrequent, the hair must be removed by epilation. They are cases requiring the closest attention, as the disease is rarely eradicated, especially in extensive cases, in less than from two to eight months, and even longer, but by the patient and intelligent use of the means already described, tinea tonsurans will ultimately be cured; the treatment accomplishing this, consisting of general measures to correct the soil and of local measures to destroy the parasite.

Among the remedies which have undoubtedly aided in the cure of the disease, more frequently than any others, may be mentioned: Sepia, hepar sulphur., phytol., rhus tox., arsenicum iod., sulphur, and calcarea iod.

The indications for which sepia was prescribed in the cases quoted are as follows:

Dandruff, in circles like ringworm; glandular and lymphatic swellings; itch-like eruptions; violent itching, as from insects on the occiput; eruption on the vertex and back part of the head; dry, stinging, itching and tingling; feeling sore from scratching; sensitiveness of the roots of the hair; worse at night; burning after scratching; falling off of the hair; swelling of the submaxillary glands, etc.

THE REPORT OF THE BUREAU OF SANITARY SCIENCE.

THE report of the Bureau of Sanitary Science included but one paper, and that was

The Sanitary System of Pennsylvania—Its Merits and Defects, by Pemberton Dudley, M.D.

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THE SANITARY SYSTEM OF PENNSYLVANIA—ITS MERITS AND DEFECTS.

BY PEMBERTON DUDLEY, M.D., PHILADELPHIA.

In the development and establishment of sanitation for the protection of the general public, the people's diverse dangers and incessant changes of condition and environment have rendered a universal system impracticable. The plan adopted for one State must be modified in order to adapt it to another State; a vast commonwealth needs different details from the single municipality; a sea-coast community requires a system such as would be needless for an interior town. The divers occupations of large communities of people, their unlike modes of life, their commercial relationships, and, as a result, their varying liability to ill-health, render it impossible to construct a sanitary system that shall be equally adapted to the necessities of all.

Thus it happens that in a vast commonwealth like that of Pennsylvania we find a vast diversity of conditions and of perils, so that almost all the applications of sanitary science and art are needed in the protection of the public health. Let us briefly consider her situation from the view-point of the public sanitarian.

Pennsylvania, though an inland State, is exposed to invasion by imported epidemics at a dozen different points. She has at least three ports of foreign entry, Philadelphia, Chester, and Erie, and sufficient foreign coast-wise and lake commerce to keep her in trade-contact with the most disease-infected regions of the whole globe. Besides this, and more perilous by far, a large proportion of the foreign traffic of Boston, New York, and Baltimore passes across her territory on its way to the West, the South, or the North. Until the organization of her State Board of Health three years ago Pennsylvania was practically helpless against this latter peril, and at almost any time her vast railway systems could have planted the living germs

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of a tropical or oriental plague in a hundred of her towns and villages, and scattered the seeds of death over almost her entire domain in twenty-four hours.

In the opposite direction there comes the ever-present danger of the importation of infected cattle and diseased swine. On the North, and particularly at Erie, the State is frequently threatened with an invasion of Canadian small-pox, while from the South an enemy rushes upon us at railway speed from the infected districts of the Gulf coast. Thus, besides her harbor, she has about a thousand miles of border line, threatened at a score of different points by incoming passengers, freight, baggage, and live stock.

Her "foes within" are even more numerous, and, what is more to her disadvantage, they are always present. To enumerate these foes "of her own household" in this brief paper is simply impossible. A few of them, however, may be briefly alluded to.

First, We have to note the fact that quite a large part of our inhabitants spend their days in the bowels of the earth, and their nights in rude, comfortless, and disease-breeding dens on the hill sides, or, worse yet, in the "mining towns." Another, and perhaps larger portion, spend their daylight and a part of the night-hours in work shops and factories over the sanitation of which they have no voice or control, and whose owners find it cheaper to secure successors for the workmen who die than to maintain proper sanitary conditions for those who live.

Secondly, There is a great and widely recognized danger in the pollution of our sources and streams of palatable water-supply, and in the widespread practice of adulterating foods, drinks, and medicines. In these respects our State is not above the average of her neighbors.

Thirdly, We may mention, as of prominent importance, the sanitary interests of the rising generation—those who are in our public and private schools, and those others who ought to be. In some cases it is hard to say which of these two classes is more exposed to the danger of ill health—those who are confined in close, illy ventilated, badly heated, improperly lighted, execrably furnished and abominably managed schools, or those

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others who, in spite of legal prohibition, are forced, at a tender age, into shops and factories and mines to minister to the pressing needs of their families or to satisfy the inordinate greed of the individuals and corporations for whom they toil.

Besides these that I have mentioned there are a thousand other conditions and circumstances affecting the health of our people, more or less profoundly and more or less extensively. Enough, however, has been said to show that the individual citizen or inhabitant, young or old, has far less power for self-protection against the perils of needless and unavoidable disease than against the highway robber or the midnight assassin. What provision have the people of Pennsylvania made against these dangers?

Early in the history of the Commonwealth, the danger of infection through ships arriving in the Delaware River, prompted the establishment of a rigid though, of course, crude system of quarantine, and the organization of a board of health, for the city of Philadelphia. In 1818, there was passed a Health Act for the city, many of the provisions of which are still in force, and acts, amendatory of or supplementary to this act, have given to the metropolis of the State a quite efficient system of public sanitation, though generally restricted and hampered in its workings by an ill-considered and mistaken economy on the part of those whose duty it is to provide its necessary funds.

The city of Pittsburgh is provided with a board of health, having a quite similar organization, and with almost identical power and authority.

Each of the cities of the third, fourth, fifth, sixth and seventh classes, *i.e.*, all cities possessing less than 150,000 inhabitants, has been empowered by general laws (May 23d, 1874, and May 24th, 1887) to create, by ordinance of councils, a board of health, with power to appoint a health officer, and other subordinates, and such district physicians as may be necessary. Councils may confer upon said board the power to abate nuisances, to regulate the construction of water-closets and privy-vaults, and the emptying or cleansing of said vaults; to provide for the registration of births, deaths, marriages and interments, for legal, genealogical, statistical, scientific and sanitary purposes; to investigate cases

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of infectious and contagious diseases, and take such action as may be necessary to prevent their spread; to enforce vaccination; to mark infected houses or places; to prescribe rules for the construction and maintenance of house drains, waste- and soil-pipes, and to make such other regulations as they shall deem necessary for the preservation of the public health.

Under these general acts, and the special acts previously passed, boards of health have been organized in the following cities: Allentown, Altoona, Bradford, Carbondale (?), Chester, Corry, Easton, Erie, Harrisburg (?), Lancaster, Lebanon, Lock Haven, Meadville, New Castle, Philadelphia, Pittsburgh, Reading, Scranton, Titusville, Williamsport.

The following boroughs have provided themselves with boards of health, either by special acts of the legislature or through a general act passed April 3d, 1851, viz.: Bethlehem, Braddock, Carlisle, Conshohocken, Dunmore, Jenkintown, New Cumberland, Norristown, Shamokin, South Bethlehem, Troy, West Chester, York.

In passing, let me say that there is a possibility that the above list is not absolutely correct. It is also proper to state, that the Act of April 3d, 1851, under which some of the above-named boroughs claim to have organized their local boards, does not confer such authority upon borough councils. It does, however, expressly confer upon councils themselves quite extensive sanitary police powers, especially the regulation of vaults, cess-pools, drains, etc., the abatement of nuisances, the prohibition of noxious or offensive manufactures, the regulation of interments, and the making of such regulations as may be necessary for the health and cleanliness of the borough. It has no power to create and enforce a system of registration of births, marriages, deaths and interments.

Thus, out of the five million people of this Commonwealth, at least two-thirds have no protection whatever through local boards of health. More than three millions are exposed to whatever adverse circumstances and conditions, ignorance, rapacity, dishonesty or villainy may choose to surround them with, and with only the slow and uncertain safeguards that may be

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secured through tedious and expensive suits at law—a resource far beyond the available reach of the vast majority.

Moreover, of our forty-five thousand square miles of territory, our present local boards leave at least forty thousand square miles utterly uncovered and unprotected. The quite populous communities thus exposed in our State can be numbered by hundreds.

Such was the condition of our State when the State Board of Health and Vital Statistics was established and organized three years ago. The wisdom of the legislation which led to its establishment, none will now question; but the extent to which it meets the vast requirements of our vast domain ought to have the most careful professional and public consideration.

An examination of the Act under which the State Board of Health was instituted, leads to the following very simple classification of its powers and duties.

I. EDUCATIONAL.—To investigate the causes of disease, the sources of mortality and the effects of localities, employments, conditions, habits, foods, beverages and medicines, on the health of the people, and to disseminate information upon these subjects.

II. STATISTICAL.—To supervise the State system of Registration of births, marriages and deaths, of prevalent diseases, and of practitioners of medicine and surgery.

III. SUPPLEMENTARY.—To abate nuisances, and enforce quarantine regulations in cities, boroughs, districts and places having no local boards of health, or where local sanitary regulations and laws should be inoperative.

In how far does, or can, the Board meet these requirements? To carry out the system in its fulness, it would be necessary to reach not only every city and borough, but every village and hamlet, every county and township, every physician, midwife, clergyman, undertaker and burial-ground, every factory, shop and mine, and every railway and canal, every church and school-house, every stream, and lake, and pond and swamp. All manufactured foods, beverages and medicines must be tested or analyzed, all dairies and creameries and slaughter-houses kept under inspection, and every known source of danger to public

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health, near or remote, would have to be promptly investigated, and, when practical, suppressed.

To carry on such a work would require a vast sum of money and a small army of men. The easiest and cheapest, as well as the most efficient method of carrying on this work of a sanitary police, is through local boards. But our local boards are closely restricted in their operations. They have no jurisdiction beyond their borough and city limits, save only for the protection of their public water-supply. An unblushing nuisance can perpetuate itself close to the boundary of a city, and the city board, of itself, is powerless to abate it. The collection of vital statistics is not practicable under the operation of our local boards, at any point beyond their jurisdiction. I believe that even the Pittsburgh Board cannot enforce registration of births, marriages and deaths, outside of the city, and within the county.

In order to cover the entire territory and the whole population, it is clear that the local board should be a county board, and that it should have a representative in every township, responsible for the investigation of nuisances and local epidemics, and the collection of vital statistics within his own district, and responsible to his county board and its central executive officer, and that each county executive officer should be properly responsible to the central organization. But how shall all this be secured? The State Board has no authority to organize county boards, nor indeed local boards of any kind, and it is utterly unable to make even a respectable beginning in the vast statistical and educational work for which it was organized, without the aid of such local helps.

A system of county boards, so appointed that it could not be used as a vast party-machine, and thus become useless for all except corrupt party purposes, could manage the vast business required of it with less friction, and the imposition of fewer restraints, than could be done in perhaps any other way. And a most desirable result would also be secured in that it would only exceptionally require the interposition of the central authority to settle questions as originating in one county and affecting others.

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THE REPORT OF THE BUREAU OF OPHTHALMOLOGY, OTOLOGY, AND LARYNGOLOGY.

OWING to the absence of the Chairman of this Bureau, Dr. W. H. H. Neville, the report was presented by Dr. W. H. Bigler. The following papers were presented:

Errors of Refraction and the Use and Abuse of Spectacles, by W. H. Bigler, M.D.

Foreign Bodies in the Ear, and their Extraction, by Joseph E. Jones, M.D.

Three Cases of Papillomata of the Larynx, by Horace F. Ivins, M.D.

Hay-fever, by the Allegheny County Homœopathic Medical Society.

Tinnitus Aurium, by W. H. H. Neville, M.D.

ERRORS OF REFRACTION AND THE USE AND ABUSE OF SPECTACLES.

BY W. H. BIGLER, M.D., PHILADELPHIA.

ALTHOUGH I cannot hope to present anything new in the following paper, I yet offer it, feeling that the importance of this branch of ophthalmological science cannot be overestimated, especially since it seems by the general profession to be regarded as the readiest to acquire and the easiest to practice. Almost every physician feels that all he needs to do is to get a box of test lenses, and proceed to examine the eyes of all his headache and neurotic patients, and prescribe glasses. But to test the refraction and prescribe spectacles, is something far different from curing the symptoms resulting from errors of refraction. Just as it is now considered more scientific, more skilful and more

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satisfactory to relieve strabismus by exercise and training than by tenotomy, and that by men against whom there can rest no charge of incompetence or timidity, so it seems a greater triumph of art, by remedies so to alter existing conditions that the muscles of the eye may be used without discomfort and pain, than by a mechanical contrivance to relieve them of all necessity for exertion. The joy of a child over a new toy is equalled only by the enthusiasm with which the medical profession hails new remedies, new operations, and new theories. We all know the waves of enthusiasm that have rolled over the medical world as one remedy after the other, one operation after the other, one theory after the other, has been heralded abroad. This easily excited enthusiasm has not been confined to any one portion of the medical field, it is not only in the line of antipyrine and Battey's operation, which have threatened to destroy all normal as well as abnormal heat, that we recognize this tendency to be carried away by one idea, but even in ophthalmology there have not been wanting signs of the same. The investigations of Donders into the nature and relief of asthenopia have offered such a fascinating theory to the oculist, and the verifications of its truth have been so frequent, that he has been tempted to trace almost every ailment to an error of refraction or muscular insufficiency. A wave of enthusiasm was started that swept over the land, delighting the opticians and deluging the people with spectacles. Every case of asthenopia is regarded by some would-be oculists as a fit case for spectacles, and going to an oculist is regarded by the laity as tantamount to being compelled to wear glasses.

The purpose of the following paper is again to draw attention to some points the consideration of which is often neglected in determining what course to pursue in the relief of asthenopic symptoms.

We will concern ourselves solely with so-called *accommodative asthenopia*, since it would lead us too far to consider muscular asthenopia, and indeed would be unnecessary since the general principles of treatment, which we hope to arrive at, will apply equally to it.

In order logically to arrive at my point, I will be obliged rap-

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idly to run over the well-known nature of refraction and refractive errors.

By the refraction of the eye is meant the power possessed by the dioptric system of the eye, by virtue of its anatomical structure, of focussing parallel rays of light, normally upon the layer of rods and cones, abnormally in front of or behind this layer.

In a normally constructed eye the relation between its refracting media and its own antero-posterior diameter is such that parallel luminous rays passing into the eye are, without effort, brought to a focus—hence forming a distinct image,—upon the layer of rods and cones of the retina. In reality all rays in nature are divergent, but those coming from a considerable distance, say ten feet, include so infinitely small an angle that they may be regarded as virtually parallel. Such a normally constructed eye has been called *emmetropic*.

When from any cause the antero-posterior diameter is shorter than the focal length of the refracting media, parallel rays have not come to a focus on reaching the retina, and hence do not give a clear image, the eye being in a state of rest. This condition has been called one of *hyperopia* or *hypermetropia*, far-sight.

When on the other hand the antero-posterior diameter is too long in relation to the focal distance, the rays of light coming to a focus before reaching the retina and casting upon it only diffused rays and therefore an indistinct image, we have myopia or near-sight. Should the curvature of cornea or lens be such that the focal distance is not the same for all meridians, we have what is called astigmatism, either hypermetropic, myopic or mixed, according as the refraction is either hypermetropic or myopic, or hypermetropic in one meridian, and myopic in another.

It is evident that in order that a hypermetropic eye may have distinct vision of a distant object, much more so of an object near at hand, either its own diameter must be lengthened, or its focus shortened. The emmetropic eye must undergo a similar change in order to see objects inside of one supposed distant point. The myope is helpless to see distant objects clearly, his eye is too long, and he can neither shorten it, nor lengthen its

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focal distance. The nearer the object approaches his eye, the more divergent do the emanating rays become, and the nearer to his retina is the conjugate focus pushed, until at his so-called far point, it reaches the layer of rods and cones, and he has distinct vision.

The lengthening or shortening of the eyeball by voluntary effort being manifestly impossible, the increase or decrease of the focal distance, by the strengthening or weakening of the bi-convex lens of the eye, remains the only means by which clear images of near objects can be obtained by the emmetrope, and of any object near or distant by the hypertrope, while it cannot help the myope.

This increase of the convexity of the lens is brought about in some manner by the action of the ciliary muscle, its contraction being stimulated by the attempt of the eye to obtain clear vision. This exertion of the accommodative power, as it is called, is therefore always dependent upon a positive muscular effort, and is aroused by a nervous stimulus. It is impossible to put forth this effort without consciously directing it to some object. Its relaxation is the natural state of rest. Pain or discomfort resulting from the exercise of the ciliary muscle is called accommodative asthenopia.

From these facts certain theoretical deductions can be drawn, which will prove of practical benefit.

From the fact that the act of accommodation is voluntary and depends upon a visual impression received and a conscious effort to make this more distinct, we may infer:

1. That where the visual impressions are weak, or very indistinct, the effort to improve will be proportionately weak. This we will find borne out by our experience. We will find the greatest defects of refraction existing with but insignificant complaint of asthenopia, and relief sought not for discomfort, but for indistinct vision.

We find this peculiarly the case in amblyopia and astigmatism, where an astigmatism of 0.25 D. or 0.50 D. will cause more nervous distress and irritation than an astigmatism measured by whole diopters. A probable explanation of this would be that vision in the former case is so nearly distinct that the eyes are

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constantly urged to clear it up entirely, thus producing asthenopic symptoms, whereas when the vision is very abnormal, the patient either does not know any better condition, or has learned the futility of any effort to correct it.

2. When there is general irritability of the nervous system, asthenopia is very frequent, irrespective of the character or degree of the error of refraction. Anything, therefore, that tends to produce or foster this irritability, will tend also thereby to produce symptoms of asthenopia. Thus we can understand how affections apparently far removed from connection with the organs of vision should so often become evidently the proximate cause of symptoms in them. (Uterine disease—nasal affections —hæmorrhoids and liver disease—dyspepsia, etc.)

3. We have here a vicious circle, in which, while the irritability of the nervous system tends to intensify the symptoms liable to result from defect of refraction, these, in their turn, aggravate the neurotic inclination and its phenomena often to such a degree that they are overlooked in the apparent paramount importance of these latter. This we see confirmed in the cases of seeming brain disease, chorea, epilepsy, etc., in which no improvement could be obtained until some chance perhaps has led to decided amelioration, in some instances even cure, by the discovery and correction of errors of refraction found to exist. Very frequently the small amount of error discovered, would tempt us almost to doubt its influence, were it not proved by the result obtained and explained by the consideration advanced above.

4. Accommodation taking place by the action of a muscle, it is logical to infer that, in considering cases of asthenopia, we should be ready to recognize their similarity to affections of muscular tissue occurring elsewhere in the body. Thus leaving out of view the self-evident conditions of paresis and spasm, we will meet with overfatigue—an insufficiency depending upon a temporary condition—and a state of muscular irritability where even habitual exertion becomes a source of discomfort and pain.

5. Even where the proper tests discover errors of refraction as the ultimate cause of asthenopic symptoms, careful examination will, in many cases, lead to the finding of other proxi-

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mate causes of these, which are of the greatest possible importance in determining our line of treatment. Further, that there is in each individual a "personal equation," which must be taken into account in the treatment (*if* discoverable).

From the above consideration we may arrive at the following general principles of treatment:

We must disabuse our minds of the idea, that, because we find on examination a defect of refraction, therefore, *of necessity*, the symptoms arising must be relieved by glasses. We must endeavor to find out whether the symptoms are not dependent upon some condition which is itself only temporary, and the relief of which will enable the eyes to perform their wonted work without other assistance. This does not necessarily imply that, during the period of treatment, nothing should be done for the relief of the unpleasant symptoms connected with the use of the eyes. But the means of relief must be employed with the intention of making them, like the cause that calls for them, only temporary.

We know that the use of glasses, by relieving the eyes of a certain amount of exertion, just to that extent renders them incapable of making that exertion. By prescribing glasses chosen according to the actual amount of emmetropia, and not with a due consideration of the concomitant circumstances, we convert a temporary evil into a permanent one, even if we relieve the symptoms and delight the patient.

Again, ordering glasses for constant use, where no inconvenience is experienced in distant vision, merely because the total error of refraction discovered would seem to call for it, is in my opinion an abuse of spectacles.

The discovery of refractive errors by the use of test lenses, or by retinoscopy, or by the ophthalmoscope, is a beautiful exhibition of special skill; but after that, to arrive at a knowledge of the immediate cause of the asthenopia, and to be able to decide upon the proper course of treatment, and to be able *not* to prescribe glasses—this requires far greater skill—therein lies the true art of specialism, founded upon the science of general medicine.

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FOREIGN BODIES IN THE EAR, AND THEIR EXTRACTION.

BY JOS. E. JONES, M.D., WEST CHESTER, PA.

THE most practical division that can be made of foreign bodies in the ear is that of:

1st. Organic.

2d. Inorganic.

The first may be divided into:

a. Organic substances which will remain dormant, or continue as they were when they entered the ear.

b. Organic material which will change, or swell, or grow, or decompose.

c. Organic bodies that are alive when entering the ear.

The second or inorganic will best be classified into:

d. Inert.

e. Poisonous, corroding, or irritating.

Organic bodies usually when introduced into the external auditory canal produce more irritation on the surrounding tissues than the inorganic, from their liability to swell, or grow, or decompose, and, by pressure or direct action on the mucous membrane of the ear, will cause more rapid and violent symptoms of irritation, calling the patient's attention to the source of the pain, requiring a more prompt appeal to be relieved, save when the inorganic substance is a caustic, or, by its ability to combine with the tissues in juxtaposition to it, destroy them rapidly. Usually this can be available at times to supply the practitioner a point of diagnostic importance in determining what the substance is in the ear. Under the subdivision of organic substances that of *a* embraces articles that remain for a long time without producing irritation or change, such as stones of fruit, pieces of paper, or of wood, or pledgets of cotton. These *may* remain in the ear with almost as little change as those of the inorganic class, and, for all practical purposes, might be classified with them in the treatment.

But those of subdivision *b*, composed of organic material

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which changes after entering the auditory canal, such as peas, or beans, pieces of bread, grains of corn, or of coffee, wool, cotton, pieces of meat or cheese. These absorbing moisture from the tissues of the ear gradually swell until pressure produces the most violent pain, with destruction of the mucous membrane and ulceration, inflaming all the surrounding tissues, or by decomposition, generate such irritating products that the same or worse results follow, which necessarily result in great difficulty of extraction by the impacted position of the offending body, or filling the whole aperture with a foul mass, which will call upon all the inventive genius of the surgeon to extricate.

That pieces of cotton can remain dormant for a long time is proved by a case that presented itself in my office recently. A man of forty-five years called to have his hearing improved, which he said I had done for him two years, or more, before. On examination with the speculum and reflected light the ear was found completely filled, and apparently sealed over. The wonder is that he could hear at all. On loosening up the debris and washing it out, I seized a tough piece of something which revealed itself as a pledget of cotton, which the man affirmed had been placed in the ear more than two years before by myself, he, supposing it should remain, had not taken it out. It had produced no irritation, and save for the accumulation of the cerumen about it, which obstructed his hearing, would have still remained.

When organic bodies which are alive enter the ear, the distress is immediate, and mostly excruciating on every movement of the insect. Even when the pain is not so violent the distress produced by the movements of the bug is, to many, very alarming.

Almost every kind of small insect has been known to enter the opening, and, as a rule, it goes to the deepest portion of the canal, to avoid the touch of the finger which is speedily thrust after it. A flea in the ear is a source of the very greatest distress, often causing the most violent reflex nervous symptoms. Larva of flies, etc., come under this division, which are sources of great suffering and trouble to remove.

The second grand division, that of *inorganic bodies*, contains,

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first, inert substances, such as beads, buttons, stones, slate pencils, pins, and the like, which may remain in the canal for a long time, and, being forgotten by the patient, are not discovered by the physician, as no violent symptoms urge a consultation.

There are cases on record where they have remained in the ear for years. But not so with bodies that are inorganic, which can directly irritate the mucous membrane of the ear by corrosion or by acting chemically upon it, as pieces of fresh lime, or potassa, or nitrate of silver, etc. These produce in the canal, and, in fact, the whole ear, the same violent symptoms they would in other parts, as in the eye or the throat; and the resultant affection is often more distressing and lasting.

The severe symptoms produced by a foreign body in the ear vary all the way from *nil* to the most excruciating suffering. Articles of the organic class vary greatly; some, being much smaller than the lumen of the canal, do not make any pressure, and so with very slight changes may remain for months and years, if undisturbed, without pain and only slight deafness. But when such substances begin to swell, pressing upon the mucous membrane of the auditory canal, squeezing the tissues between the body and the bone, the aching becomes distressing all throughout that side of the head, and often extends down the neck and on to the face. At first it may be so general as not to locate its point of generation in the ear, and be indefinitely defined as general neuralgia, or attributed to cold or rheumatism, at other times to toothache or sore throat. But as the distress grows more violent the ear swells, the soreness and pain become more located in and around the organ, while it soon develops a high grade of inflammation, running on to suppuration, accompanied by the most intense suffering.

Severe reflex subjective symptoms are at times created, even when the external phenonena are not decided. The foreign body pressing upon the mucous lining of the ear catches the fine filamentous extremities of the trigeminus and that of the vagus between the exotic body and the bony structures, pinching it severely, creating in the main branches of these important nerve structures violent irritation, awakening in other organs the most varied distress, often producing epileptic seizures,

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toothache, neuralgia, giddiness, vomiting, cough, chills, soreness of the throat, sneezing, violent and continued headache, changes in the vision, etc.

So when there presents a patient with any severe head symptoms, and at the same time some complaint of the ear, even though it be but slight, or, in fact, if no complaint be made at all, the ear should be thoroughly examined and the obstruction removed.

To remove a foreign body from the canal of the ear is in many cases easy, but at others requiring the greatest care with the finest manipulation of appropriate instruments. Small substances which do not fill up the cavity of the canal can be either picked out with a pair of fine long forceps, like those of Burnett, or scooped from their hiding-place with the curved end of a Gross' curette, or, which is easier still and usually much more efficient, they may be washed out with a well-directed small swift stream of warm water.

Washing out the ear of a patient seems simple enough, and may be easily done if you have the proper apparatus, but devoid of this who of us has not had a sorry mess in squirting the water into a patient's face, or down his neck and back, or over his clothes, much to the chagrin of the doctor and the disgust of the patient. Even with the best of instruments it requires tact and skill to so regulate the stream or direct the nozzle of the syringe that the water from it may be of the proper size, or force, or direction and accomplish the end desired without driving the body further into the ear, and wedging it tighter *in* a more unpromising position, thus increasing the difficulty of extraction and augmenting the patient's pain. Thus managed it may take us hours to accomplish what should be done in a few moments. Experience has taught me that the fountain syringe, with a ten- or twelve-feet-long pipe and the ability to elevate or lower the bulb at will, is the best syringe to use, provided you have a screw-stop on the end of the tube just above the nozzle, and not a "spring-snap" to control the exit of the stream. A two-quart size is the safest to have, lest at times just when you need the most water you will have to stop to refill it. All can be prepared that is needed at once, and, medicated or not as de-

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sired, is hung up and out of the way. With a cord and small pulley this can be placed at any needed elevation With the long tube it can be used anywhere over the office, and not require the patient to be thrust into a corner. With the screw-stop any sized stream can be produced, and rapidly and effectually stopped when so needed, while with the snap-stops it must be all turned on or all off, and they often leak, much to the discomfort of all interested. With this instrument many irritations in the ear would be easily and speedily relieved; whereas without it the physician will shun the trouble and often lack of success, and the patient dread the discomfiture of the use of the old-fashioned hand syringe or of that with the compression bulb. The most of physicians have but two hands, and, when one is used to hold the nozzle and the other to compress the bulb, there remains no ability to attend to anything else. With this arrangement of the fountain syringe, only one hand is occupied, and the other is found very useful in many ways.

The cup to receive the discharge when using the syringe should be made so the patient can hold it. Let it be square, with sides bevelling outwards, and around the base a projecting heavy wire into which the patient can easily hook his fingers and hold it firmly against the side of his neck and out of the operator's way.

This arrangement of a syringe can be used profitably in many other ways. It can be converted into an irrigating apparatus, either for hot or cold water, and for almost any organ in the body. For washing out the bladder it has no equal. For diseases of the eyes it is most admirable. They can be washed out with direct current, or sprayed with hot, cold, or medicated solutions. For the nose it takes the place of the old-fashioned douche or siphon; a continued stream can be gently or rapidly forced through the posterior nares, washing or driving out foreign bodies from that organ, cleaning or medicating the parts with ease, and can be made to fill the whole cavity of the turbinated bones by partially closing the anterior nares.

For the stomach, it facilitates the operation of "washing out," so that by elevating or lowering the bulb you can inject or siphon out at will.

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Artificial feeding can be executed with the greatest ease either by the stomach or rectum, and that with the least amount of disgust.

In diseases of the rectum everything is under much better control, and in cases of intussusception large or small appliances can be gravitated into the whole bowel in the mildest and surest mode.

We can readily see how conveniently the vagina and uterus can be cared for by its use. In fact, how any physician can get along without a good and conveniently arranged fountain syringe in his office, in treating diseases of any of the orifices of the body, is beyond my comprehension.

With this practical digression, let us return to the consideration of the more troublesome bodies that infest the ear.

In cleaning out inspissated cerumen from the ear I have never had anything to compare with the use of the fountain syringe. Softening the obstruction by the temperature of the water, then with an expert direction of the stream getting its force behind the mass, invariably dislodges the hardest cakes with a promptness which I never knew before using this simple contrivance.

The most trying, and often the most difficult, thing to extract is a smooth hard bean which has become swollen, and by pressure externally is jammed into the canal, so that the whole calibre of the duct is occupied. The more urgent first symptoms of the case, with a gradually increasing severity of the pain, would attract the surgeon's attention to an organic substance. To the touch with a probe no definite instruction is given, for the exterior is so smooth and hard, that it gives the sensation of a piece of bone covered with mucus.

Whatever the obstruction may be, only an ocular inspection of it can verify the diagnosis, and should be resorted to in every case, with reflected light by means of artificial illumination, which is better and more easily controlled than the direct rays of the sun, using always the reflecting mirror and speculum. Care should be exercised that the obstruction is not pushed further into the canal with the probe or speculum, so that by its pressure against the tympanum great injury be created—even to its destruction.

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If much irritation has been set up and considerable time supervened since the entrance of the foreign body, the mucous membrane may partially, or even wholly, close over the exterior end, and lessen the definiteness of what is to be done. Yet it is exceedingly important to know definitely what is to be accomplished before we commence to do it, especially to be sure that there is a foreign body there before we undertake the process of extraction. To seize a smooth round surface with the forceps is usually an impossibility. Should the smallest opening be discovered on any side of the obstruction, a fine strong stream of warm water might be made to dislodge the obstruction. If not a flattened quill probe slid gently down the *lower* side of the canal, raising the extraneous substance up and sliding it along the *upper* surface to the opening, will accomplish what no other method or manner of performing the extraction will. Always keep in mind that the course of the lower side of the canal is downwards and inwards and the upper surface upwards and outwards.

But should this fail the next best plan is to clean the exposed smooth surface of the bean as well as possible, and with a small camel's hair brush dipped into some of the best softened glue rest it against the obstruction, and by blowing into the ear soon cool it and dry the glue sufficiently to hold tenaciously to the brush. Few fail in this, yet there is left another resort, namely, to crush the bean and take it out piece-meal, a difficult and dangerous task; still, by proper illumination and gentleness in handling the appropriate instruments, safety to the ear can be gained.

The most of the foreign bodies to be extracted are smaller than the calibre of the external auditory canal, and nine-tenths of them can be taken out either by the skilfully directed stream of warm water from the syringe or with the quill scoop.

But we have to be prepared and always ready in expedients for the remaining tenth of the cases. Numerous other instruments have been invented and are found serviceable at times. Hinton's rectangular forceps will often render prompt service, so will Politzer's forceps, and the toothed ones of Wilde, or those of Pomeroy or Bumstead. At other times a very fine angular

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shafted ear-hook with wire loop will be just what is needed. Usually I have found Gross' ear scoop and hook of little use; there is too much bend to the scoop and very little tractile power to the hook.

As to the extraction of a living foreign body from the ear, there is nothing equal to the fountain syringe, using a *very small* soft nozzle with a strong stream and passing it carefully well back behind the insect or larva, having first dropped into the ear a few drops of chloroform. The success is prompt.

THREE CASES OF PAPILLOMATA OF THE LARYNX.

BY HORACE F. IVINS, M.D., PHILADELPHIA.

It is not intended that this article shall deal especially with the cyclopædic knowledge of papillomata of the larynx; neither is it believed that it will contain anything of especially original value to the laryngologist; but it is hoped that these three cases which I shall submit to your consideration may prove somewhat interesting, from the fact that such cases are so seldom reported in our literature. Especially is this true where an undoubted laryngeal neoplasm has disappeared during the administration of an internal remedy, unaided by surgical means.

Case I.—On the 22d of May, 1884, a boy, æt. 13, was brought to my office for the diagnosis of an affection of the throat. He presented the following history: When six years of age, he suffered from severe dyspnœa with aphonia and general loss of flesh. He was taken to a laryngologist, who diagnosed a "cystic tumor" of the larynx, a portion of which was removed, but the dyspnœa not being relieved, it was found necessary to resort to tracheotomy. Following the opening of the windpipe, all of the symptoms were promptly relieved, with the exception of the aphonia, which remained constant.

The general health has since been good, save for an attack of typhoid fever in 1882, from which he speedily recovered. Two weeks before his first visit to the office, the canula was removed

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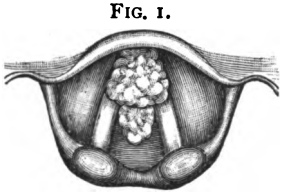
for the purpose of cleansing; it was, however, left out so long that it was impossible to replace it without the assistance of a physician, when Dr. J. W. Strong was summoned, who later referred the patient to me. As the breathing was not embarrassed with the tracheotomy wound closed, it was deemed advisable not to re-insert the tube. Medicines were prescribed with the hope of relieving the permanent loss of voice and profuse expectoration. There was no cough and no pain.

As no improvement followed, the patient was brought to my office as already stated.

Status præsens.—General condition good; the laryngoscope showed the existence of a large laryngeal tumor; it was a granular, grayish-looking mass, which apparently sprung from the anterior commissure of the larynx. It seemed to be composed of two portions: the lower, larger portion extended between and below the vocal bands, and reached beyond the middle of the larynx, measured antero-posteriorly; the upper but smaller por-

FIG. 1.



tion rested upon the surface of the bands and upon the lower growth, which extended farther back than did the upper. Thus more than one-half of the glottic length was closed by this rather soft, warty growth.

The epiglottis was so dependent as to prevent a complete view of the growth except during forced inspiration and forced expiration.

An operation was advised, to which a ready assent was given. Although no dyspnœa existed, I was afraid to operate upon so large a growth without the presence of the tracheal canula, consequently it was, with difficulty, replaced.

On the following day a series of probings was instituted in order to accustom the throat to the presence of instruments. A soft probe was used at first, but later a metal one was employed.

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On the 29th of May, Schrötter's tube-forceps were used, and a large portion of the upper growth and a small part of the lower were removed; no hæmorrhage and almost no pain ensued. On the following day the forceps were again used, and portions of the growth removed. This was repeated at intervals until the 1st of June, when the last of the tumor was evulsed. Alcohol was applied to its base by means of a cotton-covered probe. Later, a 60-grain solution of nitrate of silver was applied for the purpose of preventing a recurrence of the papilloma.

On the 7th of July the canula was removed, as there was no laryngeal inflammation present, and no tendency towards a reformation of the neoplasm. There was, however, a slight thickening of the mucous membrane at the anterior commissure. No attempt was made to close the external opening, as it was feared that some granulation or hypertrophied tissue might prevent free respiration, but as this did not occur, and as there was no return of the original trouble some months after the removal of the tube, the edges of the wound were carefully denuded and brought together by means of stitches. Unfortunately, one of the stitches gave way as the result of exercise on the ball-field.

August 3d, 1886, no change was manifest in the appearance of the larynx, the voice was normal, and respiration perfect. The small wound was again closed, but, as at first, unsuccessfully, owing to the development of a temporary cough; but, on the 9th of April, 1888, the pin-hole opening was finally closed. The voice, the breathing, the general health, and the larynx itself, with the exception of the thickened point of tissue already referred to, were normal.

Case II.—Mr. ——, æt. about 50, consulted me on the 13th April, 1885, at the suggestion of Dr. E. R. Snader. The patient said that for a long time he had had trouble with his voice which had been very changeable, being sometimes quite audible, while again it was lost. Six months before his first visit he contracted a cold, which resulted in a permanent loss of voice, without pain, and cough had only developed recently.

In 1884 he consulted a specialist, who diagnosed a tumor of the larynx and advised operation. This was declined, and some weeks later, after a severe paroxysm of coughing, the growth was ex-

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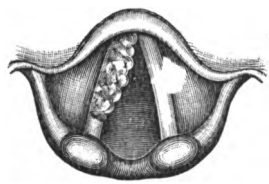
pectorated; the voice became suddenly clear, and remained so for a number of months, when the hoarseness gradually returned. The uvula had been clipped a number of months before, but with no permanent relief.

Status præsens.—Hoarseness marked; with effort could speak quite audibly in a high pitch; without effort the voice was rough, rasping, and indistinct. The laryngoscope showed the presence of a large growth on the right vocal band. The tu-

FIG. 2.



mor extended from the anterior extremity of the band to within two lines of the arytenoid cartilage. The whole width of the visible band was involved.

The throat and mouth were so exceedingly sensitive that it was impossible to introduce an instrument into the larynx. It was necessary, therefore, to have him practice, semi-daily, with a probe until the parts were sufficiently tolerant to admit instrumentation.

On the 21st of the month two small pieces were removed by modified tube-forceps without cocaine; the drug was used later and a large portion of the growth removed.

This procedure—with cocaine—was repeated every few days until the neoplasm was destroyed, when the iodide of glycerine was applied. The day's operation was always terminated either because the tumor was obscured with blood or because it was considered best not to further irritate the larynx.

On the 19th of August a slight redness was all that remained, and the voice was almost normal. Various remedies were employed, chiefly sanguinaria nitrate and argentum nitricum.

In November the voice again grew hoarse, owing to a return of the growth, which was removed as before, but this time the voice did not regain its normal character, owing, apparently, to an hypertrophy of the bands.

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On the 22d April, 1887, several months after the preceding treatment, some of the tumor was discovered, but was not removed, owing to the patient's inability to spare the time from his arduous duties. Since that time, although he has promised to continue the treatment, he has not done so.

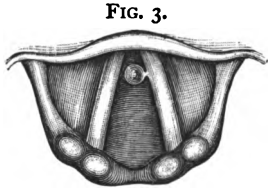
The voice is about as it was eighteen months ago, although it was much better in the interim, owing to the expectoration of a portion of the papilloma. The growth is now chiefly confined to the free border of the vocal band.

It is well known that these tumors frequently recur after removal, but perseverance in such treatment usually eventuates in cure.

CASE III.—Mr. D., æt. about 55, was referred to me by Dr. R. B. Weaver in November, 1883. He had long complained of a hoarseness which was very irregular, words being nearly inaudible here and there during conversation. There was considerable expectoration, but no pain and no dyspnœa.

Examination revealed the presence of a chronic follicular pharyngitis, a chronic laryngitis, and a very marked hypertro-

FIG. 3.



phy (?) of the left ventricular band. The enlargement was so extensive as to nearly hide the vocal band below it. It was with great difficulty that a view could be obtained, owing to the dependence of the epiglottis, which it was sometimes necessary to elevate with a laryngeal probe. The condition was treated both locally and constitutionally until the enlargement had greatly subsided; I then lost sight of the patient for a time; when I again saw him I discovered a small, round, cherry-red tumor attached to the anterior portion of the left vocal band at the junction of the middle and anterior thirds. It was attached by a pedicle to the under surface of the free border of the band. During normal respiration the tumor dropped below the bands;

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during forced expiration it was thrown up between them, and if a tone were produced directly after such forcible expiration, the tumor would rest on the vocal ligaments, the pedicle being caught between them. Thus was explained the irregular voice. The tumor was about as large as a very small cherry-stone.

Although the voice was much stronger than at first, although the ventricular band was nearly normal and the catarrhal condition better, I advised the removal of the papilloma (?) as the best and most speedy way of giving relief; but to this the patient was not willing to consent. Therefore, the kali bichrom. 12x was continued internally, and powdered alum was applied to the larynx as before.

This internal remedy was continued for some months, and although the voice was much better, the tumor had not changed in appearance. At that time sanguinaria nit. 3x was prescribed and taken once a day for about three weeks, then no remedy was given for some weeks, when the sanguinaria was resumed. It often happened that the patient would not call for five or six months, but in March of this year, the tumor was but little larger than a pin's head. It had lost its redness, and appeared to be almost ready to be expelled.

When seen to-day—September 18th—the tumor had entirely disappeared, leaving the vocal band smooth; but a considerable part of the laryngeal catarrh had returned. The voice was weak but regular in volume.

In the first and second cases the diagnosis was confirmed after the removal of a part of the growth, so that there can scarcely be a doubt as to the truth of the opinion; but in the third instance, I was alone guided by the laryngoscopic views, which, though so difficult to obtain, revealed such a characteristic condition that there can be, it seems to me, but little doubt of the correctness of the conclusions.

That nature will occasionally relieve these growths is quite evident as recorded in the second case, but it seems equally true that they are not free from return even though nature has removed them quite satisfactorily. It is not right, therefore, to make, as some have done, the unqualified statement that "these

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tumors are reproduced as the result of instrumental irritation." That nature does seem to completely cure these pathological formations is apparently demonstrated in a case where a tumor was situated on one of the glosso-epiglottic folds. I had seen the neoplasm twice, and had made arrangements to operate two days after the patient's second visit, but on the day appointed, the growth had disappeared, the patient saying it was gone in the morning when she awoke, but she knew nothing further of it. There has been no return of the tumor.

This is, of course, only one of numerous cases which have occurred, some of which have been reported, whereas many, no doubt, occur without recognition, or, if noted, are not reported.

In the first and second cases internal treatment seemed to have no influence, though long tested; in the third case, the growth evidently decreased in size during the time that the remedy was being taken, and finally disappeared during this summer. It is not possible to say that the remedy was the cause of this cure, but let us trust that it had its influence for good.

In the first case the result was all that could be desired; in the second the treatment was unfortunately discontinued at the critical period; and in the third the tumor is gone, leaving us only the catarrh with which to deal.

It is exceedingly unfortunate that so few cases of cure or relief of undoubted laryngeal tumors have been reported by the members of our school. Too often remedies are lauded for cures which are very doubtful, since often no account exists of a laryngoscopic examination, and it is rarely possible to make an exact diagnosis without this aid. In other instances, there can scarcely be a doubt of the cure, so carefully was the diagnosis made and so apparent the remedial results.

Let us hope that no one will feel content to treat any well-marked case of laryngeal disease without making a careful examination with the mirror, and then let him feel it his duty not only to make notes of such cases for his own benefit, but to report such as seem to him to offer decided evidences of relief or cure, either by nature, medicine, or surgery.

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HAY-FEVER.*

BY THE ALLEGHENY COUNTY HOMŒOPATHIC MEDICAL SOCIETY.

HAY-FEVER.—Synonyms: *Bostock's Catarrh; Catarrhus Æstivus; Hay Asthma; Hay Cold; Rose Cold; Autumnal Catarrh.*

Hay-fever is a catarrhal affection of the mucous membranes of eyes, nose, mouth, pharynx, larynx, and bronchi, not unfrequently attended by dyspnœa. The affection is annual in its recurrence, and is limited to the temperate zones. Both sexes are the subjects of it, but it is more prevalent in men than in women, possibly from the circumstance that the former are usually more in the open air, and consequently more exposed to the pollen with which it is contaminated during the summer months, when the inflorescence of grasses and plants widely prevails.

The experiments and researches of Dr. C. H. Blackley, of London, England, have very clearly established the fact, that the exciting cause of hay-fever is the specific irritation of certain pollens floating in the air on the mucous membranes with which they come in contact in persons of some peculiar but, as yet, unknown individual idiosyncrasy, or hereditary susceptibility, possibly due to some form of psoric origin not easily traced nor readily recognized. There are no well-marked peculiarities in the constitutions of different individuals by which their susceptibility to the disease can be determined before the first attack. The severity of an attack in any particular case is equally beyond our present knowledge to foretell. Persons of all temperaments, and of both robust and delicate constitutions, are sufferers from the malady. The disease seems to have but very little respect for age, since those afflicted by it range in age from five to sixty years. In a majority of cases, however, the first attack occurs in persons between fifteen and thirty-five years of age.

Hay-fever is an acute affection, limited in its attack and duration to the seasons of the inflorescence of the following-named

* Prepared by a Committee appointed by the Society, composed of Drs. W. H. Winslow and J. C. Burgher.

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natural orders of grasses, plants, and cereals: Caryophyllacæ, Compositæ, Cruciferæ, Fumariacæ, Geraniacæ, Graminaceæ, Leguminosæ, Siliaceæ, Papaveraceæ, Ranunculaceæ, Rosaceæ, Umbelliferæ, Violaceæ, and some others, both indigenous and exotic, as, for instance, the Simarubaceæ, of which the ailanthus glandulosus is an instance; it blossoms in August, and is believed to be an important factor in the production of the annual attacks of hay-fever in this section of country. The ambrosia artemisiæfolia (N. order Compositæ) or rag-weed, as it is popularly known, and generally believed to be largely responsible for the malady under consideration in this country, is an indigenous weed, flowering in all its glory from the latter part of July to October, from Nova Scotia on the Atlantic westward to Saskatchewan on the Pacific coast, and southward to Brazil.

Unlike most other acute diseases, hay-fever occurs without any well-marked prodromal stage. The liability to attack ranges from about the middle of June to the latter part of August. Its duration depends on the presence of the exciting cause, and may last for months. The symptoms are doubtless as familiar to you as they are to the writer, and need not be enumerated here.

As a rule, hay-fever has no complications, if we except the asthmatic condition which occasionally accompanies it, and the subject speedily recovers on the removal of the exciting cause, which continues until the appearance of snow and frost.

TREATMENT.—Zuelzer says (Ziemssen's *Cyclopædia*, vol. ii., p. 551, American edition): "Treatment is still powerless against hay-fever." It would be superfluous to add anything to what has been said by Dr. Winslow in regard to the general hygienic and prophylactic treatment. It is a difficult matter to determine the exact value of medical treatment during an attack of the malady under consideration. For instance, a shower of rain will not only lay the dust, but will also remove, temporarily, the pollen floating in the air. Hence, the subject of hay-fever is always greatly relieved after a fall of rain. Again, active exercise will increase the number of respirations and, consequently, of pollen-grains inhaled in a given time, inducing a corresponding aggravation. A person remaining in-door, with comparative

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freedom from dust as well as spores, amelioration of all the symptoms is soon apparent, while in the open air (unless soon after a fall of rain) the symptoms are all aggravated. The quantity of pollen in the atmosphere varies greatly during the prevalence of the disease. When grasses, cereals, plants, and weeds are throwing off spores in great profusion the disease is augmented, and conversely as they diminish the affection abates in proportion.

A medicine may be carefully selected and well indicated, in any individual case, and yet the disease be intensified while the patient is taking it; or, on the other hand, a medicine may be prescribed hap-hazard and the patient rapidly improve from the time of taking the first dose. In the former case, the aggravation is due to the increased pollen-grains ripened, thrown off, and wafted in every direction by the currents of air; and in the latter by their diminution. Hence the difficulty in determining to what extent the malady can be alleviated or controlled by medication. Constitutional treatment should be employed during the intervals of attacks, with the view of overcoming the predisposition.

The following medicines have been employed with apparent benefit: Aconitum, ailanthus, allium cepa, arsenicum album, arsenicum jodatum, ammonium muriaticum, asarum Europeum, arum triphyllum, badiaga, benzoic acid, bovista, camphor, cyclamen Europeum, croton tiglium, euphorbium, euphrasia, gelseminum semp., grindelia, hydrocyan. ac., ipecacuanha, iodine, kali bichromicum, kali hydriodicum, lobelia, lachesis, mercurius solubilis, moschus, natrum carbonicum, natrum arsenicatum, natrum muriaticum, nux vomica, opium, pulsatilla, phosphorus, rumex crispus, sabadilla, sanguinaria, sanguinaria nitrate, sambucus, silicea, sticta pulmonaria, stramonium, sulphur, tartar emetic, taxus baccata, zincum phosphoratum.

The special applicability should be carefully looked up in the Materia Medica, and compared with the symptoms and conditions of any case in hand before prescribing.

J. C. Burgher, M.D.

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THE GENERAL HYGIENIC AND PROPHYLACTIC TREATMENT OF HAY FEVER.

The best way to cure hay fever is to remove the causes, *i.e.*, remove some of the causes from the patient and the patient from some of the causes.

Morbid conditions of the general system and of the nose and bronchi predispose to hay fever, and increase its symptoms and their violence. I am not prepared to say that hay fever would not occur in a person who had no diathesis or naso-bronchial lesions, because atmospheric causes are very powerful, and we cannot yet estimate their exact influence, besides neurasthenic and dartrous conditions arise very rapidly, and furnish rich soil for development of the disease, but I know that a large number of hay-fever patients, who have applied to me for relief from naso-pharyngeal and aural diseases, have presented chronic rhinitis in some form, generally that of congestion and succulent hypertrophy of the Schneiderian membrane, with the attendant train of sneezing, copious discharge, obstruction and smothered feelings, or reflex dyspnœa.

I have treated many of these patients by the usual methods followed by rhinologists, quite a number by the galvano-cautery, and succeeded in improving the local condition and greatly ameliorating subsequent hay-fever attacks.

One lady, of 26 years, has now been three seasons exempt from the disease, whereas, before I treated her nose and ears, she had annual attacks, ending in asthma of considerable severity.

Another lady patient, of 50 years, was subject to annual attacks with severe asthma, and had to go away. She has derived so much benefit from treatment of nose and throat that she has had no asthma for two years, and has remained at home in a country suburb where spores are especially abundant. Other cases come to my mind, but I forbear mentioning them here.

Much should be done in the interim of attacks to improve the general state of the system, and the physician should make a careful study of the constitution of each patient, and establish inflexible rules of personal hygiene. The diathesis must be radically changed to render a cure possible, and it is because the

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circumstances of life and labor are such that they cannot always yield to the physician's dicta that so few cures are observed.

The changes which I mean are those of habits, diet, occupation, and climate. We can regulate habits and diet with the patient's co-operation, but when we consider occupation and habitat, we are stopped by the irony of fate and the imperious dollar-and-cent edict. Then we are obliged to supply the deficiencies of exercise, fresh air, sunlight, and play as best we can, and, instead of recommending emigration, order seasonable visits to parts of the country that are suitable to the individual.

Besides all this, medicine must be given for symptoms of special significance. Departures from health will be found in the chylopoëtic viscera, which lie at the very foundation of the diathetic manifestations, and he who best corrects these will do more for his patient than he can during the annual onslaught of acute disease. But the acute symptoms of hay-fever demand careful and masterly handling of the remedies of the armamentarium medicorum, and tax the best physician to his utmost. These I leave to my learned and venerable friend who has often exercised his skill upon me during some most virulent attacks of this aristocratic and crushing disease.

We remove the causes from the patient as much as possible, but danger to life may demand that the patient be removed from some of the causes. Some patients do very well by going to a mountain or sea-side resort during the period of extreme activity of light and spores. Others are so afflicted that serious lesions are likely to result, and they are becoming crippled in their gastric, cardiac, and pulmonary functions.

In the former the disease begins in July or August and ends with frost; in the latter it begins with vegetation and lasts till snow is deep and strength is nearly exhausted.

The former may take short annual vacations to some exempt and agreeing locality; the latter should seek up and down the world for a climate that is kind and salubrious to him.

This brings me to consider places of refuge for hay-fever sufferers. There are places inland and out-land, high and low, dry and damp. It is impossible to say which is best suited for a patient. He must experiment for himself; but experimenting

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is perilous, and certain general principles may be laid down to guide physicians and sufferers in selection of a refuge.

Those living inland are better by the sea-side; those living by the sea-side are better in the mountains. The city is preferable to the country for a residence during the season of attack. The thin and nervous do better by the sea; the plethoric and irascible upon the mountains.

Persons with dry asthma are relieved upon the coast; those with moist asthma, or having free bronchial secretion, are better in the mountains.

Dense forests, mountain peaks, or large bodies of water, should lie to the south and west of the resort, wherever it may be.

When a refuge is found it may wear out. Then another kind must be sought. A patient suffering severe hay-asthma at Toledo, O., got no relief at Isles of Shoals, but found exemption at Denver, Col., so he moved there. In two years he was obliged to hunt another refuge, and, strange to say, he found it at Petoskey, Mich., not far from his former home. I suppose he is now again on his travels.

The coast of Maine has many favorable localities for hay-fever victims, and California is said to be a paradise; but I reserve much of interest in this connection for the future.

W. H. WINSLOW, M.D.

TINNITUS AURIUM.

BY W. H. H. NEVILLE, M.D., PHILADELPHIA.

NEXT to impairment of hearing, the most common symptom of disease of the ear is tinnitus,—a term employed for all sounds originating from any internal morbid changes.

It is a more or less common symptom in most forms of ear disease, and is often a very troublesome condition; indeed the distress experienced from tinnitus of an aggravated character almost passes endurance; in some cases lingering, to the great

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torment of the patient, after all apparent disease of the ear has passed away.

These sounds vary from a slight noise in the ear, of which the patient is only conscious when everything around him is quiet, to a roar so loud as to render him nearly distracted, and between these two extremes there are endless varieties and intensities.

The most frequent form of tinnitus is, probably, that caused by the interruption of the normal sound vibrations in their outward passage through the middle ear and external canal; this frequency being due to the fact that this variety is produced by the more ordinary forms of ear disease.

According to the theory of Theobald, the normal ear is filled with continuous sound. This is caused by the constant flow of blood through the large vessels in close proximity to the ear, as well as to that flowing through the vessels of the internal ear, throwing into vibrations the soft tissues surrounding these vessels, including the walls of the vessels themselves.

These vibrations produce motion sufficient to excite the auditory nerve-elements by causing vibrations of the fluids within the labyrinth, producing the blood sound of the ear.

This, being a normal condition, is not perceived, the sound vibrations escaping through the middle ear and external canal.

If, however, the passage of these normal sound vibrations is impeded by any obstruction existing in the middle ear, or external canal, causing them to be reflected back, to again impress the auditory nerve-elements, an abnormal condition is established, and the sound at once becomes noticeable.

These obstructions may be caused by the thickening of the soft tissues, or the existence of fluids in the middle ear, as mucus, pus, or any foreign body in the external auditory canal, as impacted cerumen.

Any morbid condition either in the middle ear or external canal may produce this common variety of tinnitus.

This form is more amenable to treatment than that aggravated type which it sometimes assumes, when the deeper structures of the ear are involved, and the diseased condition producing this symptom is located in the inner ear, causing a change in the pressure of the labyrinthine fluid.

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When this pressure exists, the stapes is pressed in, or drawn outward, producing noises in the ear varying in direct proportion to the force excited.

According to Hinton, diseases of the semicircular canals, ecchymoses in the vestibule, hyperæmia of the cochlea or general enlargement and fulness of the vessels of the labyrinth, would cause changes that would point to distinct pressure within the labyrinth, resulting in an increased pressure exerted on the auditory nerve-elements. On the other hand, the normal intra-labyrinthine pressure may be decreased by a lessened blood supply to the internal ear or loss of the fluid within the labyrinth.

The tinnitus experienced by a fainting person is a familar example of a want of normal blood supply in the inner ear.

If, with this morbid condition of the inner ear, there exists an abnormal condition of the sound-conducting apparatus of the middle ear and external canal, the tinnitus would be correspondingly increased.

Pure subjective tinnitus is caused by a diseased condition of that portion of the auditory nerve located between the internal ear and the brain, or in the brain centre itself.

The tinnitus in this case may be located in the frontal or occipital region, sometimes in the ear itself.

Hinton calls attention to cases where the tympanic membrane, having lost its elasticity, becomes stiff, in consequence of which any movement of such a membrane causes a crackling sound.

In some cases when fluid has collected in the middle ear in consequence of inflammation there, the symptom is produced by the air gaining an entrance through the Eustachian tube, and bubbling up through the confined fluid.

Tinnitus aurium is associated with various degrees of deafness, is often a marked symptom when the deafness is very slight, while, in other cases, slight tinnitus may be connected with a marked degree of deafness.

The *treatment* must be directed to the removal of the diseased state with which the tinnitus is associated.

All foreign matter in the external canal, Eustachian tube, and tympanum must be removed, after which the proper homœopathic remedy should be selected.

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The allopaths are always amused at our prescribing for symptoms, and ridicule the idea of removing a distressing symptom like tinnitus with the homœopathic pellet. They say it is unscientific. We are accused of ignorance, of discarding pathology.

For the purpose of illustration, let us suppose a case of deafness where the patient hears better when in a noise. If we endeavor to ascertain the cause of this anomalous condition, we are told by Kramer that it arises from auditory nerve-torpor, while Allen informs us it is caused by a relaxed condition of the drum-head. Hinton maintains it originates in a disconnection between the incus and stapes, and Dalby concludes it is owing to some nerve-lesion. Will this knowledge aid us in the treatment, or will it help us to agree with them all that it is primarily the result of catarrh? So far as curing the deafness is concerned it affords us no aid whatever.

New let us turn to our "Chronic Diseases," and under graphites we find, *improvement of hearing while riding in a carriage*, or under the provings of hydrastus canadensis, than which no better ear remedy is found in our materia medica: *Dull condition in the head, noises in the ear as from an engine.—Roaring in the ears like a partridge, on waking in the night.—Awakened at night with noises in the ears like cog-wheels.—Hears better in a noise.*

Now, if we demonstrate, as has been done thousands of times, that the pathogenetic effects of drugs can be utilized for curative purposes, the peculiar character of the deafness resulting from this catarrhal condition gives us the key to the proper remedy, while the pathology of the case becomes of small importance on account of its being useless as an indication for the treatment.

On the other hand, suppose we have a case of tinnitus produced by impacted cerumen, in the external canal, or suppose the symptom be owing to epithelial scales lying against the drum-head.

No one would think of depending upon symptoms alone as a guide to treatment in this case, but our efforts would be directed to removing these obstructions and to returning to the sound-conducting apparatus its normal vibrating powers.

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Fully appreciating the importance of understanding the pathological meaning of every symptom with which we have to deal, availing ourselves of all knowledge that will aid us in curing our cases, we claim to take in all that allopathy does, and to this we add a scientific system of treatment.

Among the ear remedies not prominently mentioned in our Repertories, and which are often very serviceable in diseases of the ear with which this symptom is associated, may be named: bromide of camphor, conium maculatum, hydrastis canadensis, soda chlorata and sulphate of quinine.

While a large majority of these cases can be successfully treated, there are others occasioned, perhaps, by some organic change in the auditory nerve, or diseased condition of the inner ear, the pathology of which is not well understood, that are incurable. In such cases the distressing tinnitus must remain an opprobrium until the science of otology is better understood, we being content to admit our ignorance of the cause, and consoling ourselves with the reflection that the confession of ignorance is the first step to knowledge.

DISCUSSION.

Dr. Jos. E. Jones, of West Chester, in response to an invitation from the President, opened the discussion on the report of the Bureau of Ophthalmology, Otology, and Laryngology. He said that he proposed to speak on the subject of hay-fever, although the paper treating of it was read by title only. He said that the great question concerning this disease is, "What produces it?" We all say a pollen produces it. The action of the pollen on the mucous membranes of the mouth, nose, throat, and larynx gives rise to this condition. It should, therefore, be called pollen-poisoning, instead of hay-fever. He had often thought over the reason why, if hay-fever was due to pollen-poisoning, we all do not have the symptoms of hay-fever. He had been accustomed to answer this question by comparing hay-fever with rhus-poisoning. Some people are liable to poisoning by this plant, others are not. Let a person be poisoned by rhus tox. just once, and that person will ever afterwards be more sensitive to the action of the plant, and poisoning symptoms

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will be reproduced by very trifling exposure. So it is with the pollen in cases of hay-fever. When the person is once poisoned, then a slight exposure to the poison again will reproduce the disease. Why can we not cure this pollen-poisoning by medicine? We can relieve the patient by removing to a place where the poisoning cannot take place. That is not curing the patient, however. The speaker then asked why we could not alter the constitution of the hay-fever patient so easily poisoned by the pollen to the state in which it was previous to the poisoning. He maintained that this was homœopathic practice. We should operate with our remedies on the diatheses of our patients, and thus would we enable our patients to resist this poisoning. This was much better practice than palliation by removing the patient from home.

Dr. J. J. Griffith said that he was a victim of hay-fever He had tried every remedy recommended without securing any benefit therefrom. He was a living monument of the distress that could be occasioned by this infernal disease. He thought it the most serious disease that could disturb the comfort of man. In fact, he regarded it as a sort of purgatory. The first symptom in his own case, and the warning that the attack is about to appear, is a sensation as if a cobweb was on his nose; this he makes frequent efforts to remove by trying to brush it away with his hands. It no sooner disappears than it returns. This sensation usually commences on the 14th or 15th of August. On the 20th of August he rises feeling tolerably well, but before he is dressed the sneezing and coryza begin. He had written to physicians in all parts of the country seeking advice; he had even swallowed quack medicines, and had failed to receive any benefit.

Dr. Z. T. Miller asked what remedy had been taken by the previous speaker when he complained of that sensation as of a cobweb on the face?

Dr. Griffith replied that he had first taken graphites. He then took other remedies, and in potencies varying from the mother tincture to the millionth.

Dr. Miller asked if Dr. Griffith had taken any remedy between the attacks?

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DR. GRIFFITH replied that he had no symptoms between the attacks.

DR. MILLER thought that Dr. Griffith had taken too many remedies. His own idea concerning the nature of hay-fever was that it is an acute condition engrafted on a psoric miasm, and that there is very little benefit to be derived from treating the acute attacks. The patient must be treated and his idiosyncrasies changed.

DR. CHANDLER WEAVER, of Fox Chase, said that he had been treating three cases of hay-fever for the past eight years without doing the patients much good until the present year. He was very much gratified to find one of the patients, a lady, had gone through the disease this year with comparatively little trouble. In previous years she had had coryza, sneezing, lachrymation, laryngeal trouble, and asthma. These symptoms were so severe as to disable her from work. This year she was able to perform her usual duties with the exception of two hours of one night when, after exposure to a great deal of dust during the day, she had the old symptoms quite severe in the night. Arsenicum was the remedy that gave her this relief. In another case treated by him, Dr. Weaver said that he had been able to reduce the duration of the attacks; at first the patient suffered for six weeks; the symptoms first attacked the nose, and then spread to the chest. He had formerly been unable to attend to business until the first of October. By means of arsenicum his period of suffering had been reduced to one week. Another case he had treated with naphthalin; the patient passed through the attack better than before; it is hard to say how much the naphthalin had to do with this improvement.

DR. CLARENCE BARTLETT, of Philadelphia, said that the cases of hay-fever this year were not so severe as usual. The climatic conditions this year did not seem to be favorable to the existence of the disease. He asked Dr. Griffith if his attack of hay-fever was as severe as in former years?

DR. GRIFFITH replied that this year his hay-fever had been comparatively mild.

DR. HUGH PITCAIRN, of Harrisburg, said that he had been able to cure one case. Sulphur given between the attacks so

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changed the patient's constitution that pulsatilla perfected the cure.

DR. M. M. WALKER said that hay-fever was generally looked upon as a wealthy person's disease, which is not the case. He had treated a washerwoman, whose hay-fever was always worse when she was canning tomatoes. Her symptoms were even aggravated by being near tomato vines. This case he had helped with pulsatilla. The aggravation of the disease in this case from tomatoes had suggested to him the idea of potentizing tomatoes and making a proving of the same.

DR. ISAAC CROWTHER, of Chester, reported a case that he had cured with lycopodium. The attacks usually came on with the blooming of the roses, and lasted all summer. The disease in this case has now remained away for two summers. The symptoms which led to the selection of the remedy were constitutional. The patient had acne across the nose, and the characteristic gastric symptoms of lycopodium. He first gave the remedy in the 200th, and repeated it at long intervals, and afterwards gave it in the 6th. Only yesterday, Dr. Crowther said, that he had been called to see a case of hay-fever in a laboring man, whose paroxysms of sneezing were so violent that he had to hold himself during their continuance. He gave the man naphthalin, which has given him great relief.

The discussion here closed.

REPORT OF THE BUREAU OF OBSTETRICS.

THE report of the Bureau of Obstetrics was presented by the chairman, Dr. C. F. Bingaman, of Pittsburgh, and included the following papers:

The Character of the Pulse after Labor, by Joseph M. Reeves, M.D., of Philadelphia.

Prolapsus of the Umbilical Cord, by Wm. J. Martin, M.D., of Pittsburgh.

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THE CHARACTER OF THE PULSE AFTER LABOR.

BY JOS. M. REEVES, M.D., PHILADELPHIA.

FOR centuries past the pulse has been recognized as the one main index of what is going on within; later advancement in science has demonstrated that while it is a wonderful factor, yet it must have other symptoms in common with it to make it absolutely relied upon, and of diagnostic value. Were we to base our opinions of every possible morbid condition upon the one symptom, the pulse, we would come short in our judgment. Among other things, however, we learn from it the character of the artery itself, as well as cardiac action, which are both of importance to us.

The character of the pulse varies in many respects, but for our purpose we can divide it into expansion, tension, and volume.

When full expansion is quickly reached, and rapidly falls again, imparting to the finger a sudden stroke, it is known as a quick pulse, opposite to the condition known as slow pulse, in which the artery fills and empties itself sluggishly, due perhaps to slow cardiac contractions, or to impediment in the capillary circulation, or to loss of elasticity in the arterial wall itself. With a high tension of the pulse, we speak of a hard, tense pulse, and the volume of the pulse is of more importance than either tension or expansion, produced by powerful ventricular contraction, or interference with the blood from the arteries into the capillaries.

The average number of beats of the pulse in adult females, in health, is 75 beats per minute, more frequent during labor; during uterine contraction the arterial pressure is increased, and correspondingly diminished as the pains diminish. Holl first discovered this phenomenon, and found the following variations in a contraction lasting two minutes: First minute, first and second quarter, each 18 pulsations; third quarter, 20 pulsations; fourth quarter, 22 pulsations; second minute, first and second quarter, each 24 pulsations; third quarter, 22 pulsations; fourth

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quarter, 18 pulsations; showing very plainly the influence of the contraction over the mother's circulation; but, sometimes the pulse, with a high temperature during labor, shows a febrile state, and does not diminish with the lessening of the pains, which may warn us of an inflammatory action in the uterus itself, by long tonic contractions on the fœtus itself, after the membranes have been ruptured; or, a latent pelvi-peritonitis may be converted into an acute form simply by the acts of normal labor; so, then, the rapid pulse, not diminishing with diminished uterine contraction, will direct us to be on our guard.

When, on the other hand, the pulse becomes slow in a woman newly delivered, we may be assured that everything is doing well; the pulse should not exceed 100 during the ten days of lying-in except, perhaps, when the time for the secretion of milk arrives, then it rises to 100 or over, but, generally, between 80 and 90 pulsations; as soon, however, as the milk is established the pulse again becomes slow and normal.

M. Blot found the smallest number of beats to be 35 per minute, but says that to be uncommon, having met with it in but three cases; has observed every grade of diminution between 35 and 65, 44 and 46, however, being the more relatively frequent. Although not very satisfactory reasons have been given for the slowness of the pulse after labor, it is said that the sudden removal of the utero-placental vessels from the circulation, causing less labor for the heart, or disturbed action of the pneumogastric nerve, or repose in bed, may cause this condition.

The character of the pulse during convulsions in the plethoric woman is full, slow and tense, while, on the contrary, in the patient with anasarca, especially if of a nervous organization, it is small, hard and contracted. In tonic convulsions, which occur intercurrently with clonic convulsions, the heart's action is so disturbed as to cause an intermittent and small pulse, which is a bad omen.

Now we notice a marked change in the character of the pulse during internal hæmorrhage; the placenta becomes detached and forced down on the os uteri, damming it up, and we may have a profuse hæmorrhage, yet nothing will give us a quicker

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knowledge of that fact than the quick, thready, easily compressed pulse; decrease in the quantity of blood has marked effect upon the arterial pressure, and how remarkable it is to find how quickly the normal pressure is regained, after it has been lowered by hæmorrhage, as it is the quantity of the blood largely that makes the tension or pressure.

The pulse of puerperal fever in the beginning is but 80 or 90 beats per minute, full and tense, but usually reaches 120 per minute, sometimes as high as 160. 140 for any time at all prognosticates a fatal ending.

A case of interest, as regards the character of the pulse, came under my observation. A patient of mine, whom I was shortly to deliver, sent for me, as she said she was quite dropsical. She gave me her history, which was, in short, that, in both previous labors she had had convulsions and lacerated perineum, not operated upon after the last child, fortunately for the coming labor. On examining the urine, which was passed in quantities of five pints in twenty-four hours, it was found to contain 75 per cent. of albumen. Corrosive sublimate 3x was considered the proper remedy, and by the time a week had elapsed, a bare trace of albumen was found: she was safely delivered, and in about fifteen minutes after, showed signs of weakness, syncope, nausea, and a very thready pulse of 130 beats per minute; careful exploration of the uterine cavity was made, which showed nothing wrong, although the uterus had been relaxed, but was now thoroughly contracted, and in good condition; after seeing no change in an hour, and fearing a complication, I sent for Dr. Betts in consultation, patient by this time becoming quite blue about the mouth, and a peculiar look about the eyes. We decided the case was one of threatened convulsions; but they did not occur, although for forty-eight hours the pulse did not drop below 130, and temperature 100° and a little over, and not until the tenth day did the pulse get to 100. In all probability the albuminuria was the occasion of the rapid pulse.

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PROLAPSUS OF THE UMBILICAL CORD.

BY W. J. MARTIN, M.D., PITTSBURGH.

It is said that this accident occurs once out of every two hundred and forty cases of accouchment, some say once in three hundred or four hundred cases. I do not know whether it was my two hundred and fortieth case or not, but some time ago I was called to a case where the cord was prolapsed, the particulars of which I shall give presently. On consulting the authorities in my possession, I find recommended means and measures to be resorted to in cases of this kind, so various in character and difficult of performance, and uncertain in result, that I present the subject to the Society for the purpose of indorsing a simple (and by no means new) plan, that would seem to be so adaptable to all cases as to make any other treatment unnecessary. And yet, strange to say, the two latest authorities from our own school, Leavitt and Marsden, make no mention of this plan. I refer to the use of a sponge.

We will now see what the authorities say, and before we are through, you will find that there is enough almost to make one's head dizzy.

We will quote first from the *Science and Art of Obstetrics*, by Leavitt, of Chicago. He says: "This is a complication which does not, in any manner, retard the labor or make it difficult, but what gives it significance is the danger in which its occurrence places the fœtus. To the fœtus, prolapsus of the funis is one of the most serious possible complications of labor. In 335 cases collected by Dr. Churchill, 220 children, or nearly two-thirds, died. It is evident that compression of the cord is the main cause of so heavy a death-rate." He next speaks of the causes and signs, which we will pass by, as it is of no practical importance what the cause may be, and the signs are so plain that it would be hard for any one to err in diagnosis. As to treatment, he says: "Prolapsus of the umbilical cord constitutes a real emergency, inasmuch as a brief delay in affording relief may be fatal. The obvious indication for treatment is ,

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first, prevention of prolapse, and, second, relief of compression at the earliest possible moment. So long as the woman occupies a position on her side or back, the cord, from its very weight, will manifest a strong disposition to return after every reposition. This tendency may sometimes be overcome by carrying it deeply into the uterine cavity, but this involves the introduction of the hand. We should not hesitate to carry the hand up to the fundus of the womb for the purpose of leaving the prolapsed portions in that part of the organ.

"It occurred to Dr. T. Gaillard Thomas, to invert the uterus, and thereby bring the force of gravity in the direction of the fundus, by placing the woman in the knee-elbow, or, better still, the knee-chest position. With the woman in this position, it is sometimes found that the force of gravity alone is sufficient to restore the prolapsed cord. When the funis has thus been placed beyond the risk of compression, if the os uteri is large enough, the forceps may be applied, and the head drawn into the brim, thus preventing a renewal of the complication. If the forceps cannot well be used at this juncture, the head may be retained at the brim by firm hypogastric pressure, and the woman permitted to resume a less irksome position. This, the postural treatment, is suitable to all cases wherein there is any hope of restoring the cord to the uterine cavity; but it will usually have to be supplemented by manual and instrumental aid.

"Unfortunately, reposition, when thoroughly performed, is often extremely difficult to effect, and frequently disappointing in its results. Various instruments have been devised to aid in the manœuvre, but few possess them, and fewer still can successfully use them. The fact is that relief in most cases must be afforded without delay, and the preparation of the ingenious means recommended in many text-books, consumes the very time which determines the issue. Our own opinion is that, in those cases wherein successful reposition is at all possible, the hand is a better instrument than any yet devised, and with it we may more safely press the cord into the uterine cavity and maintain it there."

The treatment is summed up thus:

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" 1. The knee-elbow or the knee-chest position for the woman.

" 2. The use of the hand to return the cord, carrying it well into the uterine cavity.

" 3. The immediate application of the forceps, or supra-pubic pressure, to prevent a recurrence of the complication."

He then says: " Efforts at complete reposition often fail. In a certain number of cases labor has advanced too far to admit of a return of the cord to a situation high enough to escape compression, and this, too, in some instances where there is good ground for hoping to save the child's life. Nor should we forget that prolapse of the funis does not always necessitate protracted interruption of the fœtal circulation. If pulsation has not been long absent, and labor is progressing rapidly, it may be completed in a natural manner in time to preserve the fœtus.

" Again, if compression has not been long continued, and the pelvic structures are in a favorable condition, the forceps may be applied, and labor terminated without delay. If the head still lies at the brim, and all efforts at reposition of the cord have failed, we may have recourse to version. This is a point of great nicety, since the operation of podalic version augments the maternal dangers. Engleman says that version, preceded by judicious postural treatment, is the method to be followed, which promises most for the life of the child in prolapsus of the cord, when complicating head presentation."

Dr. J. H. Marsden, in his "Hand-Book of Practical Midwifery," says of prolapsus of the cord: " This is one of the most fatal accidents, so far as the safety of the child is concerned, that occurs during labor. I need not spend time pointing out the diagnostic signs by which prolapsus is detected. When the cord is felt prolapsed, it is or ought to be easily recognized; it is not easy to imagine how it can be mistaken for anything else that may occur, or anything else mistaken for it." He says further, and very truly and worthy of note, "That if we be convinced that the umbilical cord is presenting before the rupture of the membranes, we should watch the case most assiduously, and make an examination immediately after the waters break. We shall then probably find the cord more or less prolapsed, and, if so, this will be the moment for decided action." Among

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the various expedients that have been advised for remedying this accident, Marsden says that "Some direct us to carry up the cord with our fingers and hook it upon the chin of the child when the head presents. Others instruct us to hang the loop upon one of the limbs of the fœtus. Some again would simply place the prolapsed portion within the womb, and retain it there for a few subsequent pains. Others advise us to turn, or apply the forceps, according to the presentation, or the distance to which the presenting part has sunk into the pelvis. The two latter expedients, one or the other may be successful or even necessary in some cases, as, for instance, turning when the shoulder and arm present. The other methods mentioned are apt to fail from the fact that the cord generally prolapses again and again, unless the pains be sufficiently vigorous and the pelvis sufficiently wide to bring the head rapidly down, so as to occupy the space to the exclusion of the funis, and terminate the labor very speedily."

Marsden then describes the postural treatment in a very clear and practical style; he says, "Dr. Thomas, of New York, in the year 1858 proposed a method of treatment which he termed the postural method, and which in the large proportion of cases of this accident is likely to take the precedence of all other methods of treatment. His plan consists in placing the woman upon her knees and elbows, her face resting upon a pillow. The prolapsed cord is then carried up into the womb with the fingers, and, gravitation then acting in an opposite direction, it does not again descend. After retaining this posture for ten or fifteen minutes, that is till after the occurrence of a few pains, the patient is suffered to resume the usual obstetric position upon the left side. This method is said to be very successful in saving the life of the child, and avoids all risks to the mother, such as she necessarily incurs in the operation of turning, and even too hasty delivery with the forceps."

Sir J. Y. Simpson gives the following rules for the management of a case of prolapsus of the umbilical cord:

"1st. If pulsation of the cord be wholly stopped, do not interfere.

"2d. If you discover the prolapsus before the membranes

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burst, endeavor to return the cord above the head. If this attempt fail and the passages be well dilated, turn the child. You may do this without rupturing the membranes."

If the membranes have already ruptured, and the head be entering, or have entered, the pelvis:

"1st. Endeavor to return and retain the cord above the head.

"(*a.*) With the fingers.

"(*b.*) With a sponge.

"(*c.*) With some rough body.

"(*d.*) With an appropriate instrument.

"(*e.*) By hooking it over a limb of the fœtus.

"(*f.*) By placing the patient on her knees and elbows.

"2d. If you cannot return and retain the cord, place it in the most empty sacroiliac space.

"3d. If necessary, hasten the labor by relaxants, forceps, etc.

"4th. Never venture to turn the child unless the presentation be preternatural."

One of the most recent works on obstetrics is that of Cazeaux & Tarnier, Eighth American Edition, with an Appendix by Paul F. Mundé, M.D., in two volumes of 1221 pages, published in 1887. One would suppose that such an exhaustive work would mention everything, but it does not, as we shall see. In speaking of this subject of falling of the cord we find the following: "As regards the treatment the delivery might be left to the powers of nature, 1. Whenever there is a certainty that the child be dead. 2. When, though the infant be living, the membranes are only ruptured as the head becomes firmly engaged in the excavation, and when, from the fact of the contractions being energetic, there is every reason to hope that they alone will be sufficient to terminate the labor promptly; which, in fact, usually occurs in women who have a non resistant perineum, from having previously borne children. And 3. When the head is small, the pelvis large, and the cord situated in front of one of the sacroiliac symphyses, for then it is only necessary to return the cord into the vagina to protect it from contact with the air. But notwithstanding these favorable conditions, it will be necessary to watch the state of the cord attentively, and to apply the forceps as soon as the pulsations are found to grow

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weaker or to become intermittent. Under all other circumstances the intervention of art will be indispensable. In a presentation of the breech, the operator ought to search for the feet if the presenting part be still above the superior strait, or bring down the groins with the blunt hook, if it has descended into the excavation.

"In a presentation of the vertex or face, where these parts have not as yet engaged in the excavation, we should first endeavor to reduce the cord. Several plans have been recommended for this reduction, but the manual method, the oldest of all, is still entitled to the preference, notwithstanding the great number of instruments that have been proposed for the purpose. The operator can always proceed with greater facility behind than on the sides of the pelvis close to the sacroiliac symphyses, the right hand will be used when the cord is to the left, and the left one if it is at the mother's right. Where the loop is small it is only necessary to push it up by the middle; but in the contrary cases, it is to be gathered up and pushed back little by little, just as the taxis is usually performed in the reduction of hernia. But merely pushing the cord back into the uterus will not be sufficient to protect it, and it must be carried up above the superior strait, and the hand retained in the vagina during several contractions to prevent it from falling down. Some accoucheurs, fearing that it could not be kept in position, notwithstanding this plan have directed the introduction of the whole hand into the womb, with a view of placing the cord on one of the child's limbs; though this precaution is useless in most cases, it would certainly be preferable to podalic version where there is a slight contraction of the pelvis.

"But the instrumental method must be attempted, when the smallness of the external parts, or an undilated os uteri, renders the introduction of the hand very difficult or impracticable. Some of the various instruments proposed for this purpose might then be used. One of the simplest and best is to take a gum-elastic male catheter, of the size No. 9, armed with its stylet, and having a piece of narrow ribbon introduced into the last eye of the catheter, which is retained there by the extremity of the stylet; the ribbon is next attached to the um-

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bilical cord, without drawing it too tight, being thus secured, the extremity of the instrument carrying the cord is then directed along the hand that had previously been introduced into the vagina and placed within the uterine cavity.

"When the reduction is completed, we must wait until the head becomes engaged, before we withdraw the instrument; then the stylet is first removed and afterwards the catheter."

A description of Thomas's postural treatment, and the following case, presumably by Mundé, finishes the article on prolapsus of the cord:

"In a case of this kind I used another manœuvre, which proved very successful. The patient was a young woman in her first labor, which had made little progress, dilatation being incomplete, when the waters were discharged, carrying with them a fold of the cord. The head presented and the dilatation was too imperfect to think of carrying the cord with the hand to the fundus of the uterus. I made several attempts to return the prolapsed loop in the same way that one tries to reduce a hernia, and to get it above the head, but it always slipped down again. To prevent it from being compressed, I passed my entire hand into the vagina, slipped my two fingers into the orifice between the head and the margin of the superior strait, and thus kept them alongside of the cord which they protected, and of whose pulsations they were cognizant. My fingers, therefore, had to bear the pressure at each pain; fortunately the labor progressed rapidly and dilatation was completed in about an hour. I then withdrew the hand, applied the forceps quickly, and delivered a living child."

Guernsey's Obstetrics, a work with which we all are, or should be, very familiar, although not a new book, gives us something new, or at least different, about the management of prolapsus of the cord, from any we have consulted. I will digress for a moment here to say, that it is strange to find that the Faculty of the Boston University School of Medicine, in its announcement for 1888, does *not* recommend Guernsey's Obstetrics for the study, or for the general reading and reference of its students. It is also strange to find that the faculty of the New York Homœopathic Medical College, in its announcement for 1888,

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does *not* recommend to its students Raue's Special Pathology and Therapeutic Hints.

Guernsey says: "The treatment of this complication needs to be very prompt, lest the presenting part descend and cause strangulation, and consequent death of the child. The only plan of safety possible is to take a piece of wet sponge, about twice the size of a hen's egg, and cut entirely through its centre a hole large enough to receive the fold of cord. Then pass a string through the loop of cord, and next pass the same string through the hole in the sponge. Now, by holding on to the string and slipping the sponge upward the fold of cord is drawn into the sponge. Slip the sponge well up, so as to secure a full introduction of this fold into it. Then with the fingers crowd the sponge and all well up above the superior strait. The sponge will dilate and retain all above the presenting part safely. It may be well to be prepared with a piece of sponge ready for the occasion."

This simple yet valuable mode of managing prolapsus of the cord by the use of a sponge, is not mentioned in any other work I have consulted. The following case illustrates its use: About noon of May 12th, 1885, I was summoned to Mrs. B. She was at term, third pregnancy; while sitting at dinner and without warning, the membranes ruptured with a profuse flow of amniotic fluid; frightened and weak she was helped to bed; no pain. An examination per vaginam discovered, vagina cool and moist, os patulous and dilated sufficiently to admit the examining finger; vertex presentation. I assured her that everything was all right, tried to calm her fears, and prescribed pulsat. 3, a dose every half hour, and left her with instructions that I be called when pains became established.

This woman, naturally of a nervous, sensitive disposition, although pregnant now for the third time, was childless. Her first child had been still-born, the second from some cause was delivered by instruments, and, although born alive, lived but a few hours, consequently she was in this her third pregnancy exceedingly anxious, and fearful that she would again be disappointed in her desire to have and raise a child.

In about two hours I was again called, observed that she

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was having frequent good pains. On examination found the os dilated to the size of half a dollar, vertex presenting and a loop of the umbilical cord in the vagina. I had no difficulty in pushing it up above the brim of the pelvis and keeping it there with my fingers, but it would come out again as soon as my fingers were removed. I realized at once the danger to the child, but I did not know what to do, I had never had a case of the kind, I did not remember of ever having read what to do in such a case, nor do I remember that Burdick in New York or Gause in Philadelphia had ever in their lectures told us how to manage a case of prolapsed funis.

I could not leave the case to go home and consult my books. So I informed the husband of the condition of affairs, and advised him to fetch Dr. J. H. McClelland to my assistance, upon whom I determined to shift the responsibility of the case. Dr. McClelland was sent for, I meanwhile keeping the cord up with my fingers. When he arrived, and made an examination, he remarked that we would try the sponge as recommended by Guernsey. A fine clean sponge about the size of one's fist was procured, well washed in a carbolic acid solution, and, after tying a string to it, the sponge was pushed up to the loop of cord, and then cord and sponge pushed up into the uterus above the child's head. This effectually prevented any further prolapsus. Labor progressed rapidly, and within an hour a living child was born without the aid of forceps. The sponge and placenta followed soon after.

The child is still living, and I and all concerned have great respect for Dr. McClelland and the sponge.

DISCUSSION.

Dr. J. N. Mitchell, of Philadelphia, said that he had no paper, but at the request of the Chairman of the Bureau he would make a few remarks on a case of puerperal convulsions recently observed by him, and in which all the measures employed were allopathic. "I think that it is rather extraordinary to have a Homœopathic State Society listen to the report of a case treated entirely by old-school methods, but I want to relate

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it at this time and place, in order, if possible, to bring forth discussion, and learn whether, in the opinion of those who have had experience in such cases, had the case been treated by homœopathic methods the result would have been different. The patient was one I was engaged to attend in her confinement, but was staying out of town for the summer. She was apparently so well throughout the whole pregnancy as to attract the attention of her family to the fact. She had no œdema, no headache, no difficulty in sight, and in fact she had nothing that would lead any one to suppose that there was anything the matter with her until the day preceding her attack, when she had some pain about the heart that she regarded as an inconvenience rather than a sign of any danger. But this pain increased to such an extent that the family sent for a physician, who happened to be a practitioner of the old school, who found the patient gasping for breath, and suffering from these severe pains. The heart-sounds, however, were perfectly normal. He diagnosed angina, and administered nitrite of amyl, which relieved her quickly. He went to see her again the next morning, and found her complaining of slight headache, and, on questioning her carefully, he learned that her flow of urine was scanty, and on examination it was found to be highly albuminous. This was at ten o'clock in the morning; at twelve o'clock he was hastily called, and, when he arrived, found her in convulsions, and from that time convulsion followed convulsion until she had had thirteen. There was no sign of labor. The doctor made use of bromide of potassium and hydrate of chloral, 30 grains of each, as a rectal injection, but that did her no good. He then proceeded to make use of different drugs to act on the kidneys, for as yet there was no action of the kidneys. He passed his catheter into the bladder, but failed to find a single drop of urine in that organ. He made use of chloroform inhalations at each threatening of convulsion, but notwithstanding this she would go into the convulsion. I was sent for, but it took some time for me to get there, and when I arrived she had been in the convulsions for six hours. The doctor consented to stay in the case and work with me. I made up my mind, after so much old-school drugging, there could be no special indications for any of the

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drugs of our own school, and I considered the case a desperate one, the cervix uteri was soft and os sufficiently patulous to admit the second size of Barnes's bags, which I introduced, and dilated as rapidly as consistent with safety. In two hours I delivered her of the child, which was dead and gave evidence of having been dead for some time. Just before delivery she was given two drops of croton oil, and after delivery one-half grain of morphia was administered hypodermically. Everything that is usually recommended in old-school text-books had been done. There were no convulsions following delivery, and the uterus contracted firmly. The placenta came away very nicely, and I stayed with the patient all night. Up to twelve o'clock she lay in a heavy sleep, that was of such a character that I could not make up my mind as to whether it resulted from the morphia, or was a coma, the result of her disease. At one o'clock she regained consciousness, and recognized me and those who were about her in the room; and her temperature, which had been 103°, had fallen to 100°. At this time I noticed an anxious restlessness, and her pulse, which up to this time had been good, suddenly gave out, so that she was pulseless at the wrist. We decided to give her $\frac{1}{25}$th grain of digitalin, and in a very short time after giving it she had as good a pulse as at any time before. There was no want of contraction in the uterus. I examined carefully to see if there was any hæmorrhage, either external or concealed, but there was absolutely nothing to account for this sudden giving out of the pulse. At 3.30 A.M. the heart failure recurred; but I was afraid to use stimulants, much as she seemed to need it, so we again resorted to the digitalin, and as a result the woman was soon in a sweet sleep which lasted until 7 A.M., when she again became restless and had slight threatening of heart-failure. We then succeeded in getting her to take some nourishment in the shape of a glass-and-a-half of milk. This started the croton oil to working; the kidneys also acted freely, and she passed a large quantity of urine. The flushed appearance of the face changed with the heart-failure. At 10 o'clock she again complained of the pain a little below the heart and a little below the left breast, which gradually increased in severity from that time on; gasping for breath occurred; there was absence

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of pulse, but she was conscious. Nothing would relieve her. About two hours before her death I examined her heart, but I could hear no natural sounds. There was simply an excessive bubbling sound over the region of the heart. My associate also examined the heart, and was greatly puzzled by the character of its sounds, since the sounds had been normal at the onset of her trouble. The woman fell back, and died while attempting in her agony to sit up. I mention this case, not as one in which my own treatment had been followed, but as one in which strictly old-school treatment was pursued in my absence. I ask if the result would have been different with different treatment."

Dr. Joseph C. Guernsey said that he would relate a case of puerperal convulsions that had been treated by him. He had been sent for to attend the patient, a primipara in confinement, but not finding any degree of progress in the labor he went home. The next morning she was taken with convulsions, and Dr. Knerr was sent for in the emergency. He treated the case with Dr. Knerr. They decided on belladonna as the remedy. The speaker stayed with the patient all day long, as she was having one convulsion after the other. He finally went home and studied the case carefully. The convulsions got to coming every hour. They were very violent. The eyelids twitched violently, and the patient frothed at the mouth. Notwithstanding his careful studying of the case he could find only belladonna indicated. The patient made slow progress; but the os continued to soften and to dilate until 1.45 A.M., when he found it sufficiently dilated, and then he put on the long forceps at the superior strait. He took the child away. It weighed 6½ pounds. It was slightly asphyxiated at first, but it soon began to give evidence of life. The convulsions kept on, however, and in fact they came a little closer than before. Then Dr. Knerr returned. On account of the stertorous breathing and the continued unconsciousness opium was given. At 7 o'clock the convulsions had died away; they were coming once in two or three hours. He went away again at seven and returned at ten, and found her in a profound coma. She proved to be in a state of collapse. It was then decided to give her carbo veg. When he went away that night he felt that he had seen the last of the

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patient. In the morning she had greatly improved. The improvement continued, and in due time the milk appeared, and she made a perfect recovery. She did not have one particle of chloroform or ether, nor was forcible dilatation of the os performed. She was treated in a purely homœopathic way. The patient's urine, which was examined shortly after the illness, was found to be albuminous.

Dr. J. K. Lee, of Johnstown, asked, whether, in these cases of puerperal convulsions occurring in patients who had not yet gone to full term, it was not always best to make use of forcible dilatation. He himself practiced in a field where the nearest homœopathic physician lived forty miles away from him. He could, therefore, have consultation with no one. He was obliged to always depend on his own resources. He had recently had a case in which the convulsions came on in the seventh month of pregnancy. After making diligent inquiry to ascertain the cause of the difficulty, he found that the night before she was taken ill she had eaten nearly a quart of pea-nuts, then three pears, half-a-dozen peaches, and some figs, and then she went to bed. The consequence of all this was that about four o'clock in the morning he was routed out of bed to attend her. She woke her husband by the violence of the convulsions. Vomiting set in and disclosed the cause of the trouble. During this time she had uterine pains. He gave her hyoscyamus in the mother tincture. Previous to this time the uterine contractions were steady. As a last resort he made use of forcible dilatation of the os, which happened to be soft and patulous. But the contractions of the uterus would not bring the child down, so he used the forceps. That did not stop the convulsions. The only thing that did do so was hyoscyamus tincture in drop doses. During the time she was ailing with the convulsions she had thirty-six of them. After the child was born he found that the uterus, as in all cases, was very firmly contracted. Two days after the labor this woman unfortunately took a chill, and had a severe attack of child-bed fever. For the next three or four days she knew hardly anything. Two weeks later she was out of bed and doing well. Her child lived three years, when it

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died of scarlet fever. Four years later the mother died of typhoid pneumonia.

DR. J. C. MORGAN, of Philadelphia, said that he was much interested in the subject of prolapsus of the funis. He referred to the lectures of the late Dr. Hering, who used to emphasize the importance of the spiral formation of the visceral system, and in short of the whole organism. While studying zoology in South America, he made investigations that showed that the spiral formation was traceable in every grade of animal organization. But he used to say that he would be glad to go into the dissecting-room, and demonstrate to any one that there was no exception, in any organ of the body, to the fact that the spiral formation was present. This started him on a course of observation. He found that there were left spirals and right spirals; that, where a right spiral and a left spiral came together, as at the entrance of the ileum into the cæcum, belladonna was a specific remedy. Belladonna, as all know, is an important remedy in typhlitis. By these observations of Dr. Hering, Dr. Morgan said that he was led to adopt the spiral direction in restoring a retroverted uterus to its normal position. He was also led to adopt a similar expedient in the case of prolapsed funis.

In regard to Dr. Mitchell's case, Dr. Morgan said that the symptoms of angina pectoris that were present, namely, the pain about the heart, etc., reminded him of a clinical lecture delivered by Dr. William Pepper, in which he calls attention to the comparison by pathologists of angina pectoris and epilepsy. In other words, that angina pectoris is an epilepsy of the heart. Its pathology showed it to be no more of that nature than due to ossification of the coronary arteries. The effect of nitrite of amyl in all cases of this kind in staving off the attacks is well-known, and of course the treatment by that remedy is well justified. Dr. Mitchell made the remark that, owing to the great number of drugs given, there seemed to be no indications for the homœopathic remedy. Now, when allopathic remedies have been abused, nux vomica is the remedy, *par excellence*, in acute cases as well as chronic. He thought that the return of the

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pain about the heart might be attributed to the excessive doses of digitalis prescribed.

DR. CHARLES MOHR asked, how soon after the last dose of digitalin the patient died?

DR. MITCHELL replied, in about four hours.

DR. MOHR said, that it was questionable if death could be traced to the digitalis in that case. Still that depended on the susceptibility of the patient, and the action of the heart after the digitalin had been taken. Where digitalis is given to a weakened heart, to a heart whose functional activity is failing, after its primary effects wear off, its secondary effects are to produce heart-failure. Its action may, in some cases, be so severe as to rupture the heart suddenly. In respect to the treatment of puerperal convulsions, the speaker said that he had had few cases. One case that was severe, he managed to cure by the administration of belladonna 3, given every five or ten minutes. He also dilated the os as rapidly as he could, and succeeded in delivering her of a live child. The last case he had treated, was one of convulsions occurring in a primipara, who was very impressionable and hysterical, and who had severe epileptiform attacks before she was pregnant. After her pregnancy was well advanced, she had severe convulsions, and these were controlled by ignatia 3x, frequently repeated. Although he apprehended a great deal of difficulty during her confinement, he never saw a women who was delivered with more facility or less trouble.

DR. MITCHELL said, that he did not know that he had anything more to say concerning this case. He had merely reported it in order to bring forth a discussion on the homœopathic treatment of these cases. He thought that, in Dr. Guernsey's case, it was doubtful if the remedy given produced a cure. The patient had the convulsions all night long, and then she was delivered of her baby, and lay in a stupor all night, and then came to; he thought that it was an open question whether the patient was cured, or simply got well. He abominated the idea of giving drugs unnecessarily. He did not call it a cure if the patient did not die. He calls it a cure when the convulsions cease as a result of the medicine employed. In the case he had

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related, he had often thought that the patient had really recovered from the convulsions, but had died of the heart trouble.

Regarding Dr. Martin's use of the sponge as a means of treatment in cases of prolapse of the funis, he did not favor that method as it was a dangerous expedient from an antiseptic standpoint.

DR. GUERNSEY said, that the most successful treatment of puerperal convulsions was that by the homœopathic remedy, given in a high potency. This was the method used by our forefathers, and was the most successful. He thought also that the proper treatment of puerperal convulsions would, moreover, eradicate from the system the tendency on the part of that patient to have convulsions in future confinements.

DR. JOHN MALIN said, that he had noticed that many of the reported cures of puerperal convulsions were unaccompanied by the reports of failures. In order to judge of any man's success in any one method, he should report his failures and successes alike.

DR. LEE said, that, when the child has been delivered, and the convulsions cease, they do so as a result of the delivery, and not as a result of the medicine employed. Instrumental means, he thought, were better than medicinal

DR. Z. T. MILLER asked, if every convulsion, occurring in the puerperal state, was a puerperal convulsion.

DR. MITCHELL replied, that all convulsions, occurring during the puerperal state, were not puerperal by any means.

The discussion here closed.

REPORT OF THE BUREAU OF MATERIA MEDICA.

THE report of the Bureau of Materia Medica was presented by the Chairman, Dr. Z. T. Miller, of Pittsburgh. It included, besides numerous sections of the *Repertory* which the Bureau had made its special work, also the following papers:

Arsenicum Album, by the Farrington Club, of Pittsburgh.

Provings of Zincum Picricum, by Charles Mohr, M.D.

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ARSENICUM ALBUM.

BY THE FARRINGTON CLUB, OF PITTSBURGH.

General Analysis.

Through the ganglionic system, arsenic affects every tissue in the body. It acts directly on the blood-composition—produces a complete lack of vitality in the organs of the body—a condition of asthenia. At times it produces complete paralysis.

In reviewing its general action, nine tissues and organs may be selected as being the most profoundly affected, and, naming them in the order of their liability, these are:

1. Mucous membranes.
2. Serous membranes.
3. Kidneys.
4. Skin.
5. Blood.
6. { Heart. / Circulation in general. }
7. Liver.
8. Lungs.
9. Cerebro-spinal system.

(1.) Of mucous membranes, arsenic causes a destructive inflammation. This is so wherever the tissue is found, but through its special action on the solar plexus, the poison especially centres on the gastro-intestinal mucous tract, producing irritation, inflammation and ulceration, and even going so far in its destructive work as to produce gangrene. The discharges from these mucous surfaces are always thin and ichorous. There is present a low typhoid state of the system and prostration, generally very marked.

(2.) On the serous membranes there is an action which is profound, but not so much so as that on the mucous tissue. From its action we get serous effusions, and this, combined with its action on the cellular tissue, results in œdematous swelling and general anasarca. The inflammation preceding this, is generally of the sub-acute form.

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(3.) On the kidneys it has a very deep-reaching action. It produces fatty degeneration, and the urine is loaded with albumen, and contains also epithelium, blood-corpuscles, etc. The urine may be entirely suppressed, and very frequently is much diminished.

4. On the skin, its action is superficial. The true skin is very seldom affected, and the epidermis is but rarely entirely thrown off. It remains attached loosely to the derm. When the poison is injected, the action is from within out, beginning with that layer of the epidermis which lies next to the derm. Hence it is that arsenic is not indicated in that class of skin-diseases which is situated in the deeper structures of the skin, but it produces almost every form of what may be called superficial skin-diseases.

An interesting effect of arsenic is thus described: "In a case of poisoning, two weeks after the patient had apparently recovered, the face, head, hands and feet were swollen, and the whole surface of the body was of a bright red color. The skin partially desquamated, and was tender to the touch. This was followed by an attack of psoriasis, which extended over the whole body. The hair of the head, eyebrows and eyelashes fell off, as did also the nails. In the last sentence may be noted another effect of arsenic,—that on the hair. It causes death of the hair-follicles, and, in consequence, a falling-out of the hair.

(5.) The blood.—Here, too, the action is very profound. There is produced a change in the chemical constituents of the blood. The blood-corpuscles, themselves, are disintegrated, and the proportion of blood-fibrine is diminished.

(6.) Heart and circulation.—Arsenic has a special action on the heart. It produces various lesions, such as hypertrophy, fatty degeneration and endocarditis, with the various accompanying distressing symptoms. It acts on the whole structure of the heart—muscles, nerves and ganglia,—thus stopping its function.

On the circulation its effect is to paralyze the vaso-motor nerves, thus affecting the arterial tension.

(7.) Liver.—This organ contains more of the poison than any other tissue in the body. It is affected very deeply, and in it

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are produced all the lesions tending to its disorganization. Hence it is that in induration, atrophy, cirrhosis, fatty degeneration and malignant jaundice, arsenicum is invaluable.

(8.) Through its action on the pneumogastric nerve, arsenic produces congestion of the lungs, and with this we have irritation of the muscles of the lungs and asthma. It is found very useful in bronchitic asthma.

(9.) Cerebro-spinal system.—Arsenic is a protoplasmic poison. It affects the central nervous system, destroying its life, and then the life of the nerves and muscles. It acts on the posterior portion of the spinal cord. The spinal marrow, and especially its lower portion, is always affected; hence the paralyzed condition of the nerves of the lower extremities. Stillé says: "Arsenic paralysis is nearly always paraplegic. The arms are affected as often as the lower extremities. Cramps and contractions are common, but its most invariable concomitant is neuralgia. This generally coexists with loss of sensibility to everything but cold, by which the neuralgia is brought on or aggravated. The paralysis is most complete in the hands and feet, and spreads, if it spreads at all, periphero-centrally. There is a sense of restlessness in the limbs when the pains are present. The seat of mischief seems to be in the spinal cord. Upon the base of the brain its action is specific; upon the cerebrum, sympathetic."

J. Richey Horner, A.M., M.D.

Mental Symptoms and Comparisons.

The symptoms of arsenic here presented are taken from *Hering*, *Lippe*, and *Cowperthwaite.*

There are many other valuable indications in the *Guiding Symptoms* which should be incorporated in this paper, but space prevents.

I take it for granted that the symptoms of the three working Materia Medicas are the *characteristics* of the drug, or, at least, those best confirmed; but the many others are equally entitled to place in this monograph.

The first, and very strongly-marked mental symptom of arsenicum, is:

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Anguish. Driving one out of bed at night, and from place to place in the day-time.—*Lippe.*

And despair, driving from one place to another for relief.—*Cowperthwaite.*

Hering renders it: "Cannot find rest anywhere; changes place continually; wants to go from one bed to another."

We may compare these remedies with *arsenic's* desire to go from place to place, viz., *merc.*, *rhus* and *tabac.*

Merc. Anxiety and restless change of place; ebullitions; sweat; apprehensive, imaginary fears; fears he will lose his mind, worse evenings and night; wants to go abroad; tries to flee from the house.

Rhus. Timidity, worse at twilight; restless change of place, wants to go from bed to bed.

Tabac. Is driven from place to place with anxiety and anguish from oppression of the chest in angina pectoris.

Other remedies that have this symptom, but do not correspond so well in other particulars, are:

Arg. met. Restless anxiety, driven from place to place.

Calc. ph. Restless, wishes to be at home, and when at home to go out; goes from place to place.

Helon. Restless, wants to be continually moving about.

Hyos. Restless, wants to go from one bed to another, jumps out of bed; tries to run away.

We would probably select *arg. met.* in a spinal trouble; *calc. ph.* in the wasting diseases of rickety children; *helon.* in female weakness, and *hyos.* in typhoid fever.

Actea rac. Desires to wander from place to place, or solitude; and is suitable to the melancholic condition that rheumatic women with uterine complaints get into.

Aurum met. Is driven from place to place by great anguish coming from the præcordial region; palpitation, and suicidal mood.

To continue with *arsenic*, there is

Restlessness. He finds no rest, especially at night; with sensation of coldness.—*Lippe.*

And great anxiety at 3 A.M., driving out of bed.—*Cowperthwaite.*

And intense anxiety, worse 3 A.M.—*Hering.*

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Many remedies are restless, but I find only one that has the distinctive 3 A.M. aggravation, and this is

Niccolum. Restlessness at 3 A.M.; everything feels sore; must walk about.

Aconite. Is restless, with the high fever and thirst.

Arsenic. Is restless, with the mental anguish and fear.

Rhus. Is restless; moves about for the relief it brings, while

Niccolum. Has probably laid until 3 A.M., and was compelled to get up from soreness. (Arnica.)

Iodine. Must keep in motion, day and night; the brain feels as if it were stirred up; feels as if going crazy.

Arsenic has

Fear of death and of being left alone.—*Lippe.*

Dread of death, when alone or going to bed.—*Cowperthwaite.*

Hering renders the same as Cowperthwaite.

Aconite. Fears death and predicts the day.

Lachesis. Fears death, and fears to go to bed.

Ledum. Fears death, and fears to go to sleep lest she die.

Nit. ac. Fears death, with anxiety about his disease.

Cactus. Same; thinks his disease incurable.

Coffea, *gels.*, *secale*, *asaf.*, *apis*, all fear or dread death.

Arsenic has

Madness, loss of mind (from abuse of alcoholic drinks).—*Lippe.*

Fretful, discontented, fault-finding, capricious, easily angered.—*Cowperthwaite.*

Self-willed and fearful; child captious, wants to be carried.—*Hering.*

If all the symptoms recorded are reliable, the above would show a necessity for all the books.

Lippe's symptoms we would transpose, and call it delirium tremens; and *arsenic*, where there is the intense burning and thirst with vomiting after drinking, restless anguish, etc., cannot be replaced. Other remedies for such delirium.

Lach. Sleeps awhile, and *wakes up* furious; talks continually, and wants nothing close about the neck, it chokes and smothers him.

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Nux vom. Ranks second to none, and may be given almost indiscriminately, but especially if there is oversensitiveness, nervous excitability, malicious vehemence.

Nux mos. Much less violence; slowness of the senses, imaginary fancies; awakens and knows not where he is; laughter with stupid expression.

Opium. When the alcoholic cerebral congestion borders on apoplexy, with sopor and snoring; when awake sees animals; affrighted expression of face; suited to old, emaciated persons. (*Crotalus h.*)

Calc. c. Talks about fire, rats, mice, and murder.

Coffea. Unsteady running about; imagines he is not at home; trembling hands, small, frequent pulse.

Hyos. Clonic spasms; averse to light and company; visions as if persecuted; talks to persons not present.

Cowperthwaite compares this symptom with *bry.*, *cham.*, and *nux.*

Bryonia is exceedingly irritable, and inclined to be angry; after the anger he is chilly.

Cham. Is irritable, impatient, peevish, violent anger with heat; crying, howling, seeks cause for quarrel; pure cussedness generally.

Nux vom. Is always malicious and spiteful; gets mad in a flash; stubborn, finds fault and scolds; after great anger is chilly and hot alternately; vomiting of bile; harmless words offend.

Bry. is chilly, *cham.* is hot, *nux* is chilly and hot alternately.

The *bryonia* irritability and concomitant chilliness would make you think of it in rheumatic soreness of the muscles when motion aggravates.

Chamo. Suits the persons who are greatly affected by slight ailments; who get hot and mad; a florid, red-headed mother was rheumatic, hot, and irritable; she said she dare not touch the "young ones," for she'd kill them if she did. Her husband said she was as cross as a bear. Chamo. cured her.

Nux vom. Is the victim that looks like a thunder-cloud; he has taken all the pills and bitters made; he is thin, dark, chilly, constipated, headachey.

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Hering's symptom adapts it to children, and brings in conjunction with *cham.*, *cina*, the *antimonies*, and *silic.*

Arsenic. Is captious (whatever that means), self-willed, tearful, and wants to be carried; whether relieved by being carried I cannot say.

Cham. About the same, but is *relieved* by being carried. I have seen this indication fail several times; once on the 3d, once on the 200th. I think there must be other symptoms of cham. present, at least two others.

Cina. Is fretful, peevish, pushes things away, and sleeps only when violently rocked. Cries pitifully if taken hold of or carried. (C.)

The *antimonies* are peevish, and whine if you look at or touch them; while

Silicea is the same, even when kindly spoken to.

Benz. ac. The child is cross, wants to be nursed in the arms.

Arsenic is

Determined to commit suicide, he suffers so.—*Cowperthwaite.*

Lippe says nothing about it, while

Hering dreads to be left alone, lest he do himself bodily harm.

The disposition to self-destruction, by different methods, is found under various drugs; under none more marked than *aurum met.* They become weary of life, especially evenings; have no confidence in themselves, and think others have none; with longing for death; the aurum patient is restless, but also quiet, brooding.

Actea rac. Tends to suicide, with mental depression.

Alumina. Has ideas of killing herself from seeing blood on a knife, but abhors the idea.

Ant. crud., *nat. sulf.* Wants to do the business by shooting, while

Bell., *hell.*, *rhus*, and *silic.* prefer the water.

Berb., *caps.*, *china*, *hepar*, *lach.*, *lycop.*, *plat.*, *podo.*, *psor.*, *puls.*, *spig.* are equally unanimous in declaring life a burden.

Plat. and *rhus* feel like it, but are afraid.

China wants to, but lacks courage.

Arsenic has

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Delirium at night with great restlessness.—*Cowp.*

" (but without modality).—*Lippe.*

Confusion of the head.—*Hering.*

Acon. Is delirious, especially at night; ecstasy; fancies.

Bapt. Is delirious, especially at night.

Dulc. Is delirious, especially at night with the pains.

Lach. Is delirious at night, muttering, drowsy, red face, slow difficult speech, etc.

Rhus. Is mild, thinks he is roaming over fields, or hard at work.

Arsenic causes

Great fear and anguish; sees ghosts day and night.—*Cowperthwaite.*

Lippe says nothing about ghosts. Neither does *Hering* in his " Condensed."

Carbo veg. Is afraid of ghosts nightly.

Bell. Imagines she sees ghosts, hideous faces, or insects.

Hyos. Sees persons who are dead, or living persons who have not been present (in delirium).

Hyper. Sees spirits and spectres.

Stram. See ghosts, hears voices back of his ear.

Arsenicum has also

Sad, tearful, anxious mood (ign., lycop., nat. m., nux mos.; puls.; rhus tox.).—*Cowperthwaite.*

Despair, he finds no rest, especially at night, with anguish.—*Lippe.*

Sad, tearful, anxious mood.—*Hering.*

Nearly every remedy in the book might be compared.

Abies nigra. Is very low-spirited and melancholy, with a dyspepsia, that feels like a hard-boiled egg in the stomach.

Apis. Is very tearful and can't help crying.

Arg. nit. Is sad, despondent, thinks it's no use, can't succeed anyhow.

Aurum. Despondent, weeping, dejected, thinks he is unfit for this world. Can't succeed. It's very peculiar how both the noble metals produce this feeling. Silver and gold are supposed to make anybody generally happy. Deposited in the stomach or pocket may make the difference.

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Digitalis. Is sad, depressed, apprehensive, greatly aggravated by music. (Nat. c., sabina.)

Graph. Sad and despondent, thinks of nothing but death, apprehensive, inclined to weep.

Ignatia. Is full of grief, but does not give it away, except by sighing. Troubles may be real or imaginary.

Lach. Is sad and anxious, especially in the morning after waking.

All the *mercuries* are low-spirited and disposed to cry.

Nat. mur. Melancholy, depressed, sad and weeping, but gets mad if you condole with her.

Nux mos. One moment laughing, the next crying. Weeping, gloomy.

Phos. Sad, apprehensive, depressed, filled with gloomy forebodings.

Plat. Low-spirited, sad, apprehensive, inclined to weep, especially in the evening. (Merc., rhus.) Worse in the house, better out-doors.

Puls. Melts immediately. Cries first, and tells her complaints afterwards.

Rhus. Sad, anxious, apprehensive, evening and night. Desires solitude, inclined to weep. Worse in house, better walking in open air.

Robinia. Very low-spirited, with sour stomach and sour stools.

Sepia. Great sadness and dejection, with much weeping, dark forebodings of future.

Sulph. Melancholy, sad, despondent, inclined to weep.

These are, presumably, the symptoms most characteristic of *arsenic*, since they appear with slight difference in wording in the three working Materia Medicas now in use. There are, however, many more in the "Guiding Symptoms" and Allen's Encyclopædia which should be embraced in this review of *arsenic*, but are omitted for want of space.

Arsenic. Is averse to meeting acquaintances, because he imagines having formerly offended them, though he knows not how.

Baryta c. Dreads men and strangers; imagines she is being

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laughed at or criticised, hence so fearful she will not look up.

Aloes. Hates people, repels every one.

Amm. mur. Involuntary aversion to certain persons.

Clemat. Fears to be alone, but disinclined to meet otherwise agreeable company.

Conium. Aversion to man, and yet averse to being alone.

Fluoric ac. Feeling of indifference to those he loves best. Becomes interested and converses pleasantly with strangers.

Lycopod. Dread of men, wants to be alone, or dread of solitude, with irritability and melancholy.

The "Guiding Symptoms" gives about four pages of mental symptoms, some of which are cured. Allen has about the same. Among them are

Arsenic. Thoughts, ideas, crowd upon him; he is too weak to keep them off, or to hold on to one idea.

China. Has ideas, and projects crowd his mind, especially in the evening.

Cuprum. Is full of erroneous ideas, one follows the other quickly.

Stan. Cannot get rid of an idea once fixed in her mind.

Coccu. Has a fixed idea upon one unpleasant subject; is absorbed in herself, and observes nothing around her.

Calc. c. Can't go to sleep on account of many involuntary thoughts.

Fluoric ac. Also loses sleep *in the evening* from crowding of thoughts.

Hepar. Excess of thoughts prevents sleep *after midnight.*

Jacea. Goes to sleep late on account of ideas crowding on the mind.

Sabad. Many ideas occupy the mind, prevent sleep or make it light.

Sepia. Wakeful, sleepless rush of thoughts.

Staph. Goes to sleep late on account of crowding of ideas.

Arsenic also has

When alone he falls to thinking about disease and other things which he can scarcely keep out of his mind.

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Calad. Is apprehensive and careful about his health.

Lil. tig. Is apprehensive as from impending disease or calamity. Fears she has heart disease, fears she is incurable.

Arg. nit. and *Cactus.* Both fear the disease will result seriously, or the disease is incurable.

Cicuta. Fears long spell of sickness before death. In old men.

Iris. Fear and dread of approaching illness.

Arsenic. Has gloomy forebodings while lying in bed. In the evening fears something may have happened to his relatives.

Croton tig. Feels as though some misfortune would befall himself.

Psorin. Is full of fear and evil forebodings.

Calc. c. Fears some misfortune is going to happen.

Clemat. Is low-spirited; fear of approaching misfortune.

Cuprum. Is sad, restless, as if some misfortune were approaching.

Lil. tig. Is apprehensive of calamity.

Mezer. Feels the apprehensiveness in the pit of the stomach as when expecting unpleasant news.

Can. sat. Also feels it in the pit of the stomach, but has oppression of breathing and palpitation.

Arsenic. Has a fixed idea that he and his family will die of starvation.

Bryonia. Fears she will not have the wherewithal to live while in childbed.

Z. T. MILLER, M.D.

HEAD AND FACE.

1. Intense headache, periodical, worse from light and noise; belladonna, sanguinaria canadensis, spigelia, bryonia.

2. Severe hemicrania, fifth pair of nerves, malarial in origin; cedron, cactus, kalmia, kreasote, magnesia phos., mezereum, robinia.

3. Heaviness in head, humming in the ears, better in the open

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air, worse in the warm room, worse from rest; cactus, ignatia, sulphur, iris versicolor, aloe, china.

4. Face deathly color, pale, waxen, yellow, cachectic look, sunken, covered with cold sweat, hippocratic; veratrum alb., camphor, china, carbo vegetabilis.

5. Œdematous swelling of the face, looks livid, pale, greenish; apis, apocynum can.

1. Intense headache, periodical, worse from light and noise.

Belladonna has the same symptom, but the pain is aggravated by motion, walking, or even as much as moving the eyes, while in arsenic the patient must move about.

Bryonia has the same as belladonna, distinguishing it from arsenic, while the different constitution and complexion of the patient affected will enable us to differentiate between bryonia and belladonna.

Sanguinaria has a periodical headache which comes every seven days, begins in the morning, and grows worse till evening, thereby differing from arsenic whose pains are worse after midnight.

Spigelia, in respect to its headache, is somewhat similar, but the mental symptoms will be a guide. Under *arsenic* there is the well-known anxiety and restlessness, while *spigelia* has rather an apathy, a disinclination to motion or work.

2. Severe hemicrania, fifth pair of nerves, malarial in origin.

Cactus has this affection of the trigeminus, but it is worse on the right side of the head and from motion. The pains are sure to appear if the patient misses his meal.

Kalmia has neuralgic pains of a shooting character, the time of aggravation is the morning or at noon, and it is better in the evening.

Cedron has a neuralgia which returns at exactly the same hour each day, and continues only during the day.

Kreasote has tearing and jerking pains, mostly in the left side of the head, and very often due to a decayed condition of the teeth.

Magnesia phosphorica, neuralgic pains which change about

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from place to place. Comes on at night; during the day is perfectly well.

Mezereum has a neuralgia in the cheek-bone or over the left eye, the pains leave a numbness, are *worse* from warmth.

Robinia has pain in the jaw-bone, which feels as if it were dislocated. With this there is intensely sour taste and vomiting.

3. Heaviness in the head, humming in the ears, worse in the open air, better in a warm room.

Cactus has the same heaviness in the head, as of a weight in the vertex; it is better from pressure but is worse from motion, affects too a different class of subjects.

Iris versicolor has a headache which is somewhat similar, but is worse from motion, and in the open air, and is generally accompanied with lowness of spirits and melancholia, the violence of the gastric disturbances suggests another point of difference.

Ignatia gives the same symptoms, but is worse in the morning and in the early evening. It is, too, generally found in nervous, hysterical persons.

Sulphur has a hemicrania which is worse in the open air, and is generally thought of when there is an accompanying scrofulous or rachitic condition. The *sulphur* patient is lean, and stoop shouldered. The *arsenic* patient is weak, much emaciated and of a malarial tendency.

Aloe has a sense of weight on the vertex, but all its symptoms are worse in the heated weather and in hot rooms, and better in cold. Arsenic reverses this. The aloe patient is phlegmatic and indolent.

Cinchona off. has the pressive headache with roaring and singing in the ears, but this is generally the result of depletion of the system of vital fluids. An anæmic headache.

4. Face deathly color, pale, waxen, yellow, cachectic look, sunken, covered with cold sweat, hippocratic.

Veratrum album has a cold face, the forehead especially being covered with cold sweat, the extremities are cold, there is a general lack of superficial circulation. The mental symptoms will

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help to differentiate, as will also the length of time of the illness of the patient. Under *veratrum* and *camphor* the prostration has been sudden and extreme. Under *arsenic* it is generally due to a long-lasting disease. The *camphor* or *arsenic* patient is anxious and apprehensive, which is not so under VERATRUM.

The *camphor* patient is not thirsty; the *veratrum* patient wants *cold* water and plenty of it; the *arsenic* patient wants anything to drink but only a little at a time, though often.

Under *carbo vegetabilis* the face is very pale, but more of a grayish-yellow color. There is a decided lack of animal heat; the nose, cheeks, and extremities are cold; the breath may be cold; the pulse is threadlike and almost imperceptible.

5. Œdematous swelling of the face, looks livid, pale and greenish.

Apis, the face is much swollen, but more especially under the eyes. There is a flushed, red and hot face, like *bell.*, with the burning pain. There is no thirst even with a dropsical condition. In arsenicum the dropsy is from causes deeper seated than with apis.

Apocynum has this œdema of the face, but the mental, chest, and stomach symptoms are entirely different.

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EYES.

Upon the eyes and their appendages arsenic produces: itching, drawing, and pressure around the eyes, swelling of the lids, pains on moving the eyelids, as if they were dry and rubbed against the eyeballs; agglutination of the lids; increased lachrymation; drawing and pressure, but especially tickling, itching and *burning* (the characteristic sensation produced by arsenic). The conjunctiva is reddened, there is photophobia, the pupils are contracted; in fact there is every symptom of inflammation. There is a feeling of sand in the eyes, obliging him to rub them. Burning in the eyes; eyes hot, with burning, sore pain in the balls. Pulsative throbbing in the eyes, and with every pulsation a stitch; after midnight. Sensitive to light, and often keeps

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eyes closed. As regards vision itself, it is obscured and weakened.

In non-inflammatory œdematous swelling of lids and conjunctiva arsenicum and apis are both indicated, both have the burning, hot lachrymation, but the discharges are not acrid and excoriating in apis, though they feel burning hot. The œdematous lids of arsenicum are pale, those of apis a blue-red. Arsenicum has relief from warm applications, while apis has relief from cold applications. Arsenicum has aggravation at and after 12 P.M., while apis has aggravation in the first part of the night.

Rhus tox. is similar to arsenicum, and has œdematous swelling of lids; chemosis; hot, gushing lachrymation; erysipelas; and there is a tendency to the formation of pus. The pains are worse at night, particularly after midnight, warmth relieves; the erysipelatous lids are of a dusky-red, and, together with the cheeks, are studded with small, watery vesicles. Both euphrasia and arsenicum have the acrid discharge and the formation of phlyctenulæ on the cornea, and both are indicated in scrofulous cases. But arsenicum has more marked burning—burning like fire, especially after midnight. This symptom is not always relieved by the application of hot water, but frequently so. Nor have we in euphrasia the marked restlessness we have in arsenicum. Euphrasia has a bland coryza and excoriating lachrymation.

Sulphur is indicated in scrofulous inflammation of the eye, especially with the characteristic tendency of this remedy to congestion. The eyes are red and injected, and there is a feeling as of a splinter of glass in the eye. The inflammation is worse in hot weather and when near a hot stove.

Aconite is indicated in inflammatory affections of the eyes arising from exposure to dry, cold winds. There is a great deal of heat and burning in the eye. The eye feels as if full of sand, and there is aggravation from sunlight. The pains are so intense that the patient wishes to die; he declares that he cannot stand them. Allium cepa is indicated in catarrhal conjunctivitis when the lachrymation is not excoriating and the nasal discharge is (reverse of euphrasia).

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EARS.

Carroll Dunham says, with regard to the ears, no symptom seems characteristic, except that almost all the paroxysms of pain, wherever located, begin with roaring in the ears. But when it is remembered that great debility and exhaustion attend the pains of arsenic, and that these in turn are apt to be attended by roaring in the ears, this symptom will not be regarded as indicative of a special affection of the ear. He says: Let me, however, caution you against supposing that because arsenic has hitherto produced no definite ear affection, it cannot, nevertheless, cure it; because it will cure ear affections when it is indicated by the *general* constitutional symptoms of the case.

Besides the roaring in the ears Hering gives:

Unusual sensitiveness to sound.

Ringing in the ears.

Hardness of hearing, cannot hear the human voice.

Stitching-tearing from left meatus auditorius outwards, more in the evening.

Yellow discharge from the right ear, with dryness of the nose; the hearing is not weakened.

Discharge of cadaverous odor, profuse, ichorous.

In hardness of hearing of the human voice arsenicum might be compared with phosphorus, in which the hearing for the human voice is impaired; associated with this is roaring in the ears as from rush of blood. Sounds reverberate unpleasantly in the ears.

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TEETH.

GRINDING THE TEETH WHILE ASLEEP. So does *can. ind.* *Cina grinds* the teeth *at night*, presumably when asleep. *Podo.* also *grinds* the *teeth* at *night* during dentition. Acon., cicuta, colch., helleb., hyos., plumb., secale, stram., and zinc. grind the teeth without any modality recorded. The conditions leading to the grinding are:

Acon. During the febrile state; dry, hot skin; thirst and restlessness. The amount of water drank and red heat of skin, quite different from *arsenic.*

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Cina. With vermicular affections.

Cicuta. During the delirium of cerebro-spinal fever, as also helleb., hyos., stram., and zinc.

Colch., plumb., and secale. In rheumatic, neuralgic, and puerperal troubles.

ARSENIC. THE TEETH SEEM LONG, BECOME LOOSE, ARE SENSITIVE TO PRESSURE AND TO COLD WATER.

ACON. Is sensitive to *cold air*, instead of cold water as with ars., and the aching is in sound teeth.

AGNUS. Is quite opposite to both *ars.* and *acon*, in that it is *aggravated* by being touched by WARM FOOD OR DRINK.

ALUMIN. The teeth feel *loose* and *elongated*, worse *chewing*, in open air and evening.

AMM. CARB. Teeth feel *long* and *dull.*

ANT. C. Stitches from *drawing air into the mouth.* (See caust., aurum.)

ARN. The same as *ant.*, but is worse from external warmth; opposite Ars. *Bismuth*, toothache is relieved by taking *cold water* in the mouth, worse when the water becomes warm (fluor. ac.). *Bryonia*, also *relieved* by *cold water* and *aggravated* by *warmth. Coffea*, is relieved by holding *ice* or *ice-cold* water in the mouth, but is aggravated by hot or warm drinks. *Bismuth*, *bryonia*, and *coffea*, and fer. phos. are almost identical in this particular.

BROM. Is also *sensitive* to *cold water.* As is *arsenic.*

CAMPH. Teeth seem *too long*, cutting toothache which seems to originate in the swelling of a submaxillary gland.

CARBO AN. Causes *looseness* of the teeth that are sensitive when chewing.

CAUST. Has painful *looseness* and *elongation* of the teeth, with pain in sound teeth on *drawing in cold air*, like *ant. c.* and *arn. Clemat.* is *better* from *drawing cold air into mouth* (nat. sulph., mez.), and from cold water. The teeth are *too long*, painful, with free saliva, as with *merc.*, but *merc.* is WORSE from WARMTH, from COLD or WARM things. (See Coffea.)

GLONOINE. The teeth *feel long*, with throbbing pain.

HYOS. The teeth *feel long and loose* when chewing.

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LACHNAN. Upper incisors and eye-teeth *feel as if loose*, with sensation of soreness when touching with the tongue.

LYCOP. The front teeth *loose*, or as if *too long*.

MAG C. Has *looseness* of teeth with swelling of gums.

MERC. PROT. The molars feel *too long*, worse bringing them together.

MERC. COR *Loosens the teeth*, they pain and fall out.

MEZ. Feel dull and *elongated*.

NAT. SULPH. Like clemat. is relieved by cold air.

NIT. AC. Teeth feel *elongated*, become yellow or *loose*.

RHUS. Teeth feel *too long* and *too loose*, feel as if asleep.

SILIC. All the teeth feel *too long and loose*.

SPONG. The teeth feel dull and *loose* while chewing.

STAN. Loose and *elongated*, with jerking shortly *after* eating.

SULPH. Teeth *feel too long*.

ARSENIC HAS A JERKING TOOTHACHE EXTENDING TO THE TEMPLES, RELIEVED BY SITTING UP IN BED, TOOTHACHE RELIEVED BY HEAT OF THE STOVE.

AGARIC. Shooting from *right* lower teeth *up into head;* tearing in lower molars, *worse from cold air*.

ALUMINA. The pains extend *downward* instead of up, as *into the neck*, *larynx*, or *shoulders*. (See Bry.)

ARN. The pains *extend into the ear*.

BRYON. Tearing-stitching toothache, *extending to the muscles of the neck* (alum.), *aggravated by warmth*. While ALUM is worse from open air; evenings.

HAM. Pains *extend to malar bone* and *temporal region*.

HYOS. Toothache, driving to despair; tearing-throbbing, *extending to the cheeks* and along *the lower jaw*.

KREOS. Pain *extends to temples* and *left side* of the *face*, *inner ear* and *temple*.

MAG. C. Violent toothache, suddenly *going* from one *place* to *another*, up into the *ears*.

MEZ. Boring-*stinging* toothache, *extending to malar bones* and *temples;* chilliness.

NAT. MUR. Drawing-tearing *from the teeth to the ears and throat*, after eating at night.

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PSOR. Stitches in teeth *from one side to the other, radiating to the head*, with burning in right cheek.

PULS. Throbbing-digging in hollow teeth, with drawing, *extending* to *the eyes.*

RHUS. Tooth painful, with *stinging* at root of nose, *extending* to *malar bones;* jumping-shooting, as if teeth were torn out, *extending* into *jaws* and *temples.*

SABAD. Toothache, pain often *extends over side* of the *face.*

SEPIA. Toothache in a hollow tooth, *extending into the ear.*

STAPH. Gnawing, tearing in decayed teeth; *shooting into the ear*, throbbing *in the temples.*

SULPH. Toothache, with *stitches in the ears.*

ARSENIC. SWOLLEN, BLEEDING GUMS; PAINFUL TO TOUCH.

ALUMEN. *Swelling* of gums, they *bleed* and *ulcerate.*

AMM. C. Gums very *sensitive*, they *bleed* easily. *Bleeding* of the gums. *Ambra, ant. t., bell., berb., secale.*

AMMO. M. *Swelling* of gums of *left side*, with *stitches* up to the *left temple.*

ANAC. *Bleeding* of gums on *slight rubbing.*

Ant. c. Gums *detach from teeth* and *bleed* easily.

APIS. Gums *bleed* easily. *Violent pains* in gums.

Swelling and *redness* of gums and cheeks, with sore pain and *stinging* in the teeth. Gums *sacculated*, look watery. Child wakens with screams; red spots on the skin.

ARGENT. NIT. Gums *tender* and *bleed* easily, *neither painful* nor *swollen.*

ARNICA. Gums *sore* and *swollen*, teething. *Beating and tingling* in the gums.

ASAF. *Soreness* of the gums.

ASARUM. *Smarting sensation* of the gums.

AURUM. Gums *swollen, dark red. Sore* when *touched*, or when eating. *Bleed* easily.

BAPT. Teeth and gums *sore;* by *pressing* with the finger large quantities of *blood ooze out.*

BARYTA C. Gums *bleed*, are swollen, *pale red* with a *dark* red *border.*

BELL. Extremely *painful swelling* of the gums on the *right side. Bleed* easily.

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BERB. Gums *sore during dentition. Bleed* easily.

BORAX. *Gum-boil*, with *swelling* of gum and cheek of *left side* of *face* as far as the eye, where it formed *watery blisters.*

BOVIS. *Scorbutic* gums; *bleed easily.*

BROM. Gums *pain* in the *morning.*

CALC. C. Gums *painfully tender;* swelling and *bleeding. Fistula* dentalis *lower jaw.*

CAPS. Gums *hot, bleeding, swollen, sensitive*, spongy, *retracted* from the teeth.

CARBO AN. Gums *red, swollen, painful, bleeding gum-boils.*

CARBO VEG. Gums *bleed* when *sucking them. Pain* as if *sore. Recede* from the *lower incisors. Sensitive* when *chewing. Gum-boils.*

CAUST. *Swelling* of the gums. *Tedious* suppuration of the gums. *Fistula dentalis.*

CHAM. Gums *red* and *tender during dentition.*

CHINA. *Swelling* of the gums; *mouth dry.*

CISTUS CANAD *Scorbutic swelling* of gums. *Separating from* the *teeth;* easily *bleeding, putrid, disgusting.*

CLEMAT. Gums of *left lower molars pain* as if sore; *worse while eating.*

CUP. MET. Gums *ulcerated.*

DOLIC. Gums *swollen; neuralgic pains* in them, *worse* at *night.*

DULC. *Scurvy* from *cold. Receding. Spongy* gums. *Ptyalism.*

FLUORIC AC. Gum *sensitive* over the *right eye-tooth.*

GLONOINE. *Stabbing* in the gums. *Worse* from *heat, better from cold.*

GRAPH. Painful *soreness* on the *inside* of the gums. *Swelling* of *gums* and dryness of the mouth.

HAMM. Gums *painful* and *swollen, bleed easily.* Passive, dark fluid after extraction of teeth.

HYOS. Has *great pain* of gums *after extraction* of a tooth.

IODINE. Gums *swollen* and *bleeding. Blisters form* on the *gums.* Gums *puffed*, red, *inflamed, painful* to *touch* and *bleed easily.*

KREOS. Gums *bluish-red*, inflamed on *upper left* side. *Swelling* of gum *over a tooth* not yet *through, causes convulsions. Gums bleed readily. Scorbutic, spongy, ulcerated. Bleeding* of gums and nose, *blood dark, quickly coagulating.*

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LACH. Gums bluish, *swollen, bleeding, worse* from *warm drinks.*

LYCOP. Gums *bleed violently* when *touched. Gum-boils. Fistulæ.*

MAG. C. Burning vesicles on the gums, on the inside of the cheeks, tongue, lips and palate. They bleed from the least contact.

MAG. MUR. Painful swelling and easy bleeding of the gums.

MERC. Gums painful to touch, swollen, receding from the teeth, edges whitish; bleeding; fœtid odor from the mouth. Gum-boils.

MERC. BIN. Gums swollen. Boils in the mouth.

MERC. COR. Gums swell. Covered with false membrane. Gangrenous. Bleed freely.

MILLEF. Rheumatic toothache, with diseases of gums. Gum-boils.

MUR. AC. Gums swollen. Bleeding. Ulcerating.

NAT. MUR. Gums sensitive to warm and cold things. Swollen. Bleed easily. Are putrid. Fistula.

NAT. SULF. Gums burn like fire.

NIT. AC. Gums white, swollen and bleeding.

NUX MOS. Gums bleed. Scurvy.

NUX VOM. Gum-boils which seem about to burst. Gums white, putrid, bleeding.

OLEAN. Bluish-white gums.

OX. AC. Gums bleed. Are painful in spots. Small ulcers on the gums.

PETROL. Swelling of the gums, with stinging, burning pains when touching them. Fistula.

PHOS. Gums stand off from the teeth, and bleed easily.

PLUMB. Gums swollen. Show a lead-colored line. Painful, with hard tubercles.

PODO. Great desire to press the gums together; difficult dentition.

PSOR. Ulcers on the gums.

SABAD. Gums swollen. Bluish.

SABINA. Swelling of gum around a broken tooth.

SANG. Spongy, fungoid, bleeding condition of gums.

SEPIA. *Swelling of the gums.* Dark red, painful. *Bleeding* from the *slightest touch.* Gums painful, *as if burned.*

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SILIC. Gums sore; inflamed; gum-boils. Erysipelatous swelling of gums and roof of mouth, after extraction of a tooth.

STAPH. Fistulæ. Gums white, swollen, ulcerated. Spongy, bleed when touched.

SULF. Swelling of gums, with beating pain. Bleeding of gums.

TELUR. Salivation. Gums bleed easily and profusely.

TEREB. Scorbutic affections, with bloody urine.

THUJA. Gums swollen; inflamed; dark red, in streaks.

TRIL. Bleeding from cavity after the extraction of a tooth.

ZINC. Gums pain while eating. Ulcerated. White. Bleed easily.

GUMS SWOLLEN.—Besides *arsenic:* alum., amm. m., left side. Apis, red. Arg. n., arn., beating. Aurum, dark red. Baryta c., pale red, dark-red border. Bell., right side. Borax, left side. Calc. c., caps., spongy. Carb. an., red. Caust., china, cist. c., scorbutic. Dolic., neuralgia, worse night. Ham., iod., kreos., over a tooth not through. Lach., bluish. Mag. m., painful. Merc., edges white. Merc. bin., merc. c., covered with false membrane. Mur. ac., nat. m., nit. a., white. Pet., stinging, burning. Plumb., lead line. Sabad., bluish. Sabin., around a swollen tooth. Sepia, dark red. Staph., white. Sulf., beating. Thuja, dark red in streaks.

GUMS BLEEDING.—Besides *arsenic:* alum., amm. c., ambra, ant. t., bell., berb., secale, anac., ant. c., apis, arg. n., aurum, bapt., from pressure. Baryta c., berb., bovista, scorbutic. Calc. c., caps., carb. an., carb. veg., when sucking. Cist. c., ham., iod., kreos., lach., worse warm drinks. Lycop., violent. Mag. c., mag. m., merc., merc. c., gangrenous. Mur. ac., nat. m., putrid. Nit. ac., nux m., scurvy. Nux v., white, putrid. Ox. ac., phos., stand off from teeth. Sang., spongy. Sepia, from least touch. Staph. Sulf. Zinc.

GUMS PAINFUL TO TOUCH.—Besides *arsenic:* amm. c., apis, violent. (Arg. n., not painful.) Arn., asaf., aurum, bapt., bell., extremely. Berb., dentition. Brom., morning. Cal. c., caps., hot. Carb. an., carb. veg., when chewing. Cham., red, dentition. Clemat., left lower molars. Fluoric ac., right eye-tooth. Graph., inside of. Ham. and hyos., *great* after extraction. Iod., kreos., left upper. Merc., nat. m., to warm and cold. Ox.

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ac., in spots. Pet., stinging burning. Plumb., hard tubercles. Sepia, as if burned. Silic., erysipelas after extraction. Zinc., while eating.

Z. T. MILLER, M.D.

MOUTH.

1. ARSENIC.—DRYNESS OF THE MOUTH, WITH VIOLENT THIRST. LICKS THE LIPS.
2. BURNING IN MOUTH AND PHARYNX AND ŒSOPHAGUS.
3. MUCH SALIVA, MUST SPIT OFTEN.
4. SALIVA DECREASED.
5. APHTHÆ IN THE MOUTH.
6. PAINFUL BLISTERS IN THE MOUTH AND ON TONGUE.

1. The first symptom is found under many drugs.

ACON. has *dryness* of the *mouth*, *tongue* and *lips*. Thirst. The character of thirst is what decides.

AMM. C. Great dryness of the *mouth* and *throat*.

ANT. CRUD. Dryness of the mouth (chelid.).

APIS. Dryness of the *mouth* and *fauces*. No thirst.

APOC. Dryness of the *mouth* on *waking*; thirst.

ARG. MET. Dryness of mouth, fœtid breath (apis).

ARNICA. Dryness of mouth, fœtid breath.

BAPT. Mouth and tongue *very* dry in *fever*.

BARYTA C. Dryness of the mouth, *early after rising*.

BELL. Dryness of the mouth with thirst; mouth hot.

BROM. *Mouth* dry and parched.

BRYON. *Mouth* and *lips* very dry; only momentarily relieved by drinking. *Without thirst*, or thirst for *large quantities*.

CAN. IND. Dryness of mouth *without thirst* (apis, dulc.).

CAN. SAT. Dryness of the *mouth*, *throat* and *lips*.

CANTH. Dryness of the *mouth* (gamb., lauroc., plumb.).

CARB. AN. *Mouth* and *tongue* dry (caust.).

CAUL.. *Sensation* of *dryness* in the *mouth* (coccul.).

CEPA. Dryness of *mouth*, *root of tongue*, *soft palate* and *throat*.

COCCUL. Dryness of *mouth* at night, *without thirst*. Sensation of dryness in *mouth* (caul.), with frothy salivation (Jacea.)

CUP. MET. Dry *mouth* in *brain affections*.

FERRUM. *Mouth* dry in the *morning* (graph.).

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HELLEB. *Mouth* dry, also the *palate*, with cutting and scraping on moving the mouth to swallow.

HYPER. Dry burning heat in the *mouth* and *lips*.

JACEA. Sensation of dryness of *mouth*, yet with much salivation (Coccul.).

KALI BI. Dryness of *mouth* and *lips*, relieved by drinking cold water (see Bryon.).

KALI C. Mouth feels dry, with increased saliva.

MAG. C. Dryness of mouth, especially at night and in the morning.

MAG. M. Dryness of mouth and throat, without thirst. See cocc.; also can. ind., apis, and dulc., nux m., nux v., puls.

MERC. C. *Mouth* dry with *unquenchable thirst.*

MILLEF. *Mouth* dry. Thirst.

NAT. C. Dry *mouth* and *throat*, with inclination to drink.

NAT. M. *Mouth*, *lips*, and especially the *tongue*, dry.

NUX MOS. *Mouth* and *throat* dry. *No thirst.*

NUX VOM. *Mouth* dry, parched, *without much thirst.*

PARIS. Dryness of mouth, *morning*.

PETROL. Great dryness of the mouth and throat in the *morning*, with *much thirst.*

PHOS. AC. Dryness of *mouth* and *throat;* gray, whitish coating on the tongue.

PHYTOL. Sensation of dryness in *mouth, with cough.*

PODO. *Mouth* and *tongue* dry on *waking*.

PULS. Dryness of mouth in *morning*, *without thirst.*

PSOR. Mouth *dry* and *burning*.

RHUS. Mouth dry, with MUCH THIRST.

SABAD. Mouth dry. Throat sore.

MOUTH, DRYNESS OF THE.—Besides *arsenic:*

Acon., ant. c., apis, no thirst. Apoc., on waking. Arg. m., fœtid breath. Arn., fœtid breath. Bapt., arid tongue. Baryta c., early A.M. Bell., hot. Brom., parched. Bry., and lips. Can. ind., no thirst. Can. s., and lips. Canth., carb. an., and tongue. Caust., caulo., sensation of. Cepa, and root of tongue, soft palate and throat. Coccul., sensation of; night without thirst. Cup., brain affections. Ferrum, morning. Hell., also palate. Hyper., and lips. Jacea, sensation of, with much saliva. Kali bi.,

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and lips. Kali c., feels dry, saliva abundant. Mag. c., night and morning. Mag. m., without thirst. Merc. c., millef., nat. c., and throat. Nat. m., and lips, especially the tongue. Nux mos., and throat; no thirst. Nux v., parched; little thirst. Paris, morning. Petrol., great in A.M., and throat. Phos. ac., and throat. Phytol., sensation of. Podo., and tongue, on waking. Puls., A.M., without thirst. Psor., and burning. Rhus, sabad., sabina, and œsophagus without thirst. Spigel., A.M., with stinging. Stram., and throat; they glisten. Verat. a., saliva lessened. Zinc., and post-nares, latter stopped.

VIOLENT THIRST.—Besides ARSENIC: acon., apocyn., bell., bryon., merc. c., millef., nat. c., petrol., rhus, stram.

(No thirst, can. ind., nux m., apis, mag. m.)

SABINA. Dryness of mouth and œsophagus, without thirst.

SPIGEL. Dryness of mouth mornings, with stinging.

STRAM. Dryness of mouth and throat, they glisten; thirst.

VERAT. ALB. Mouth dry, saliva lessened.

ZINC. Mouth and *posterior nares* dry, latter stopped up.

2. The second symptom will not be found so often.

APIS. Has *scalding* in the *mouth* and *throat* only.

ARUM. Mouth *burns*, and is so sore they refuse to drink, and cry when anything is offered.

BROM. Burning sensation in the *mouth*, *œsophagus*, and *stomach*.

CALAD. Burning in *mouth* and *fauces*.

CANTH. Burning pain in *mouth*, *throat*, and *stomach*.

HYPER. Dry, burning heat in the *mouth* and on *lips*.

IRIS. Burning in mouth and fauces as if on fire.

MANCIN. Unendurable burning and prickling in the *mouth*, *not relieved by cold water*.

MERC. COR. Painful burning in the *mouth*, *extending to the stomach*.

MEZER. Burning in the *mouth* and *throat*.

NAT. SULF. Burning in the *mouth*, as from pepper; mouth dry, thirst, gums red.

PSORIN. Burning, tickling, *mouth* inflamed, sore, *worse* from *warm* food, not annoyed by *cold* food.

VERAT ALB. Burning in the *mouth* and *throat*.

Thirteen remedies have burning, but all do not cover the

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ground of *arsenic.* Brom., canth., merc. c. come nearest; apis, calad., iris, mez., verat. alb., next; arum, hyper., mancin., nat. sulf., psor., least.

The first three, brom., canth., and merc. c., cover the whole tract from mouth to stomach; apis, calad., iris, mez., verat., the mouth and throat; arum, hyper., mancin., nat. sulf., psor., the mouth only.

3. The third symptom, "MUCH SALIVA, MUST SPIT OFTEN," is to be found under about two-thirds of the drugs in Hering's Condensed.

SALIVA IS INCREASED by, aloe, arg. n., bov., carb. v., cyclam., dulc., fl. ac., glon., ig., ipec., mag. m., marum., mez., nat. c., ox. ac., podo., secale, sepia, silic., stram., sulf. ac., verat. v.

4. "SALIVA DECREASED." Acon., nux mos., op., spong., verat. alb.

ÆSC. HIP. Salivation; OILY *taste,* teeth as if covered with oil. See iris v.

ALUMIN. Saliva increased, but *mouth feels dry.*

AMM. C. Much saliva must be *ejected.*

ANT. C. Saliva running, of SALTISH *taste.*

APIS. *Viscid, tough, frothy* saliva.

APOC. Constantly spitting; increased secretion of mucus in the mouth and fauces.

ASAR. Accumulation of much water in the mouth, *with nausea* (lob. inf.); mucus in the mouth of sweetish, insipid taste (*aurum,* same except nausea).

BAPT. Saliva rather *abundant,* somewhat *viscid, flat.*

BELL. Salivation *succeeds dryness* of *mouth.*

BRYON. Much *soapy, frothy* saliva.

CAMPH. Saliva, *running together,* watery.

CANTH. Salivation, *copious, tasteless, disgusting, sweet.*

CAPS. Salivation, *copious, viscid, offensive;* salivation *during* a *chill.*

CHAM. Collection of saliva of *metallic, sweetish* taste.

CHELID. *Bitter* water collects in mouth.

CINA. Much *frothy* saliva, with *rattling* of *phlegm* in *chest.*

CHINA. Salivation, *day and night,* years after the *abuse* of *mercury.* Great weakness, especially of the stomach.

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COLCH. Profuse flow of saliva, *with dry throat* (rhodo.).
CUP. MET. Frothy saliva, WITH COUGH.
DROS. Profuse flow of watery saliva.
DULC. Saliva tenacious, soaplike; gums spongy.
GRAPH. Increased flow of saliva, MUCH SPITTING.
HELON. Salivation of pregnant women and teething children.
HYDRAS. Excessive secretion of *tenacious mucus.*
HYOS. Saliva saltish (lycop.), bloody.
IODINE. Mouth filled with tenacious mucus in the morning, with putrid taste in mouth, not relieved by washing in cold water; after abuse of mercury.
IRIS. Salivation after diphtheria, with swelling of the parotids; saliva tastes greasy, slimy (æsc. hip.).
KALI BI. Saliva increased, bitter, viscid, frothy, salty.
KALI HYD. Viscid, saltish saliva during pregnancy; bloody saliva (mag. c.), with sweetish taste in the mouth.
KALM. LAT. Copious salivation, tingling in the salivary glands, immediately after eating, with sense of fermentation in the œsophagus.
KOBALT. Constant watery secretions, *with frequent swallowing.*
LOB. INF. Flow of clammy saliva, with *nausea.*
MANCIN. Saliva increased, *yellow, offensive.*
MERC. Ptyalism. Saliva *fœtid, tastes coppery* (ran. b.).
MERC. C. Ptyalism. *Salty* (kali bi., kali hyd., hyos., lycop., phos.). *Bloody* (kali hyd.), *yellow* (mancin.), tough, acrid.
NAT. MUR. Saliva *bloody* (merc. c., kali hyd., nit. ac., op., mag. c.).
NAT. SULF. Much salivation *after meals.*
NIT. AC. Saliva *fœtid, acrid, makes lips sore; bloody.*
NUX MOS. Salivation *before menses.*
PETROL. Saliva offensive.
PHOS. Saliva increased, tasting *saltish* or *sweetish.*
PHYTOL. Profuse saliva, sometimes *yellowish* (mancin., merc. cor.); often *thick, ropy, tenacious;* after *mercury.*
PLUMB. Saliva *sweetish* (puls.).
PULS. Saliva sweetish; *constant spitting of cotton-like mucus.*
RAN. B. White saliva, tasting coppery (merc.).
RHEUM. Salivation, with colic and diarrhœa.
RHUS. Saliva bloody, runs out of mouth in sleep.

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SABAD. Hot during pyrosis. Copious; nausea (lob. inf., asar.); vomiting and gagging; sweetish.

SABINA. White saliva, becoming white when talking.

SECALE. Much *sour* fluid in the mouth; spitting blood.

STAPH. Constant accumulation of water in mouth.

STRAM. More saliva, with *chills and fever.*

SULF. Saliva profuse, with *nauseous taste*; causing all her troubles. (See sabad., lobel., asar.)

TARAX. Much *sour* water accumulates in the mouth (secale); salivation, with sensation as if the *larynx* were *pressed shut.*

USTILAGO. Profuse, *bitter* saliva.

VERAT. ALB. Constant flow of saliva, like water-brash.

ZINC. Increased flow of saliva, with crawling on inner surface of cheeks.

Saliva increased.—Besides *arsenic:*

Æsc. hip., oily taste. Alum., mouth dry. Amm. c., ant. c., saltish. Apis, viscid, tough, frothy. Apoc., constantly spitting. Asar., with nausea (also lobel.), sweetish. Aurum, same as asar. except nausea. Bapt., viscid, flat. Bell., succeeded by dryness. Bry., soapy, frothy. Camph., canth., copious, disgusting, sweet. Caps., viscid, offensive, during chill. Cham., metallic, sweetish taste. Chelid., bitter. Cina, frothy, rattling of phlegm. China, day and night, years after merc., great weakness of stomach. Colch., dry throat Cup. met., frothy, with cough. Dulc., soap-like. Graph., much spitting. Helon., pregnant women and teething children. Hydras., tenacious. Hyos., salty, bloody. Iodine, tenacious and putrid taste, not relieved by washing, after merc. Iris, after diphtheria, parotids swollen, greasy, slimy. Kali bi., bitter, viscid, frothy, salty. Kali hyd., viscid, salty, pregnancy, bloody, sweetish taste. Kalm. lat., tingling in salivary glands after eating. Kobalt, frequent swallowing. Lob. inf., clammy, nausea. Mancin., yellow, offensive. Merc., fœtid, coppery. Merc. c., salty, bloody, yellow, tough, acrid. Nat. m., bloody. Nat. sulf., after meals. Nit. ac., fœtid, acrid, makes lips sore, bloody. Nux mos., before menses. Petrol., offensive. Phos., saltish or sweet. Phytol., sometimes yellowish, thick, ropy, tenacious, after merc. Ran. b., coppery. Rheum, with colic or diarrhœa. Rhus bloody, runs from mouth in sleep. Sabad., copious, with nausea. Sabina, becoming frothy when talking. Secale, sour, spitting

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blood. Staph., constant. Stram., with chills and fever. Sulf., nausea, causes all her troubles. Tarax., sour, feeling as if larynx pressed shut. Ustilago, bitter. Verat. a., like water-brash. Zinc., with crawling on inner surface of lips.

5. The fifth symptom, "APHTHÆ IN THE MOUTH."—What is known as *aphthæ* or *follicular stomatitis* is frequently confounded with the more severe lesion *ulcerous stomatitis*. The symptoms and not the name of the disease will guide. As *aphthæ* means *ulcers* in the mouth, those symptoms relating directly to *thrush* can have no comparison with *arsenic*.

ALOE. Inflamed sore spots in the *mouth*, on the *tongue* inside the *cheeks;* yellow *ulcers* on the *tongue*.

ALUMEN. Small ulcers in the mouth.

AMBRA. Blisters in the mouth, pain as if burnt, as in the formative stage of aphthæ.

ANAC. Painful vesicles in the mouth.

ANT. TART. Small circular patches like small-pox pustules in and upon the mouth and tongue.

BAPT. Putrid ulceration of the buccal cavity with salivation, well developed ulceration, cancrum oris, copious saliva, gums loose, flabby dark-red or purple flabby. Stomatitis materna, breath fœtid, feeble.

BARYTA. Whole mouth filled with vesicles, especially inside of cheeks.

BORAX. Aphthæ that bleed easily, with great heat and dryness of the mouth.

BORAX. Aphthæ with affections of the eyes.

CALC. C. Mouth slimy. Blisters on the inner surface of cheeks and tongue. Canker sores, especially during teething.

CANTH. Mucous membrane covered with small blisters.

CAPS. Burning blisters in the mouth.

CARB. AN. Burning blisters in the mouth.

DULC. Stomacace, rheumatic; also after abuse of mercury, with ptyalism and swollen cervical glands.

HELLEB. Mouth, tongue, and gums full of flat yellow ulcers, with elevated gray edges, or red, swollen bases, carrion-like odor, salivation.

HELON. Stomatitis materna.

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HEPAR S. Ulcers on the gums and in the mouth, with base resembling lard.

HYDRAST. Stomatitis after merc. or chlorate of potash, nursing women or weakly children. Peppery taste (nat. s.), tongue as if burned or raw, with dark-red appearance and raised papillæ.

IODINE. Ulcers in the mouth, gums red and swollen, receding from the teeth, bleeding slightly, with small ash-colored painful ulcers, profuse ptyalism.

KALI C. Vesicles painful, burning all over the inner mouth.

KALI HYD. Irregular ulcers, look as if coated with milk.

MERC. Mouth inflamed with *burning* aphthous ulcers. Copious, fœtid, ropy saliva; scorbutic gums, large blisters in the mouth.

MERC. C. Phagadenic ulcers on the mucous membrane of mouth, throat, or on the gums, with fœtid breath.

MILLEF. Stomacace, ulcerated gums.

MUR. AC. Stomacace of nursing children, patch on the right side of tongue large and irregular, but very deep, fœtid breath.

NAT. M. Blood-blisters on the inside of the upper lip, sore places in the mouth, very sensitive even to liquids, vesicles and ulcers in the mouth and on the tongue, smarting and burning when touched by food.

NAT. C. Flat ulcers and blisters inside the mouth, burning and painful when touched.

NIT. AC. Mucous membrane swollen, ulcerated with *pricking* pains, after abuse of mercury. (Hyd.)

NUX MOS. Aphthæ of children.

NUX VOM. Small ulcers in the mouth of putrid smell; bloody saliva runs out at night; gums scorbutic; coagulated blood is spit out.

PETROL. Ulcers on the inner cheek, painful when closing the teeth.

PHOS. Aphthous patches on the roof of mouth and on the tongue. Soreness of mouth, easily bleeding.

PHOS. AC. Cancrum oris following measles in syphilitic children.

PHYTOL. Small ulcers on inside of right cheek, very painful. Cannot chew on that side.

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PLUMB. Dirty-looking ulcers and purple blotches in the mouth and on the top of the tongue.

PSORIN. Blisters inside lower lip, burn, painful.

SILIC. Stomacace, mouth gangrenous, with perforating ulcer of the palate.

STAPH. Painful excrescences on inside of cheek. Mouth and tongue full of blisters.

SULF. Blisters in the mouth.

SULF. AC. Aphthous, mouth and gums yellow and painful.

THUYA. Aphthæ, ulcers in the mouth.

VIOLA OD. Aphthæ of infants.

6. The symptom, painful blisters in the mouth is included in the last comparison. The remedies are: Ambra, anac., ant. tart., baryta, calc. c., canth., caps., carb. an., kali c., nat. m., nat. c., psor., staph., sulf.

The *Tongue* symptoms are quite numerous.

1. Swelling of the root of the tongue, externally and internally.
2. Coating. Sides furred, with red streak down the middle and redness of the tip.
   Thickly furred, edges red.
   Whitish.
   Yellowish-white.
   Brown.
3. Tongue dry and morbidly red, with papillæ, considerably raised at the top.
   Lead-colored.
4. Violent burning on the tongue.

1. The first symptom:

ACON. Tongue *feels* swollen, burning, prickling, tingling.

ANAC. Heaviness of tongue; *sensation* as if swollen, impedes speech.

APIS. Swollen; looks dry, glossy.

ACETIC AC. Pain across the root of the tongue, impedes speech and moving of the jaw; scarcely able to talk. Gland under the tongue and on lower jaw swollen and sore to touch.

BAPT. Tongue FEELS swollen, thick, making speech difficult.

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BELL. Tongue swollen and inflamed; papillæ of deep red color. Top and edges light red.

CALC. PH. Tongue swollen, numb, stiff, with pimples on it.

CANTH. Tongue swollen and thickly coated.

CARB. VEG. Glossitis, when tongue becomes indurated.

CICUTA. Swelling of the tongue, white painful burning ulcers on the edges. Sore to touch.

CUP. Chronic glossitis.

DULC. Inarticulate speech from a swollen tongue, but talks incessantly.

HYDRAST. Tongue swollen, shows marks of the teeth.

KALI C. Tongue swollen, covered with vesicles. Tip burns as if raw.

LYCOP. Tongue swollen in places.

MERC. Swollen, glabby, takes in prints of teeth.

MERC. C. Swelling of tongue, with ptyalism.

OX. AC. Swollen, sensitive, red, dry, burning. Swollen, with a thick white coating.

PULS. Tongue feels too broad, too large.

VERAT. ALB. Tongue swollen, dry, cracked, and too red.

2. The second symptom, RED STREAK IN MIDDLE OF TONGUE, is found under *ant. t.*, *arg. n.*, *caust.*, *cham.*, *verat. v.*, *phos. ac.*

BROWN STREAK IN MIDDLE. Ailant., arnic., bapt., eup. purp., lach.

YELLOW STRIPE. Hydrast., lept., stram.

THICKLY FURRED, EDGES RED. Also ant. c., ant. t., bell., canth., fl. ac., kali bi., verat. alb.

WHITISH. Acon., æsc. hip., agar., agnus, ailant., anac., ant. c., ant. t., apis, arg. n., arn., bapt., bell., bry., carb. veg., cham., chelid., cimex, cina, china, cocc., cup., dig., eup. perf., ferrum, glon., graph., helleb., helon., hyos., hyper., ip., kali c., merc., nit. ac., nitrum, nux m., nux v., ox. ac., phos., podo., puls., rhus, rumex, sang., sarsap., sepia, stram., sulph., verat. alb.

YELLOWISH-WHITE. Acon., æsc. hip., *aloe*, ant. c., cham., chelid., cup. m., *cycla.*, coloc., eup. purp., fluoric ac., *gels.*, hyp., ip., merc., merc. jod., nux m., nux v., phytol., plumb., *psor.*, puls., rumex, *secale*, spig., stann., sulph.

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BROWN. Actea r., ailant., bapt., gels., hyos., iod., plumb., silic., spong., sulph.

The remedies italicised under "Yellowish-white" are the remedies worded exactly that way. The others are simply *yellow*.

3. The third symptom, "TONGUE DRY AND MORBIDLY RED, WITH PAPILLÆ CONSIDERABLY RAISED AT THE TIP."

ALOE. Has a dry red tongue.

ANT. T. A very red tongue, that is dry in centre.

APIS. Dry and glossy.

ARUM. Tongue sore, *red*, papillæ elevated.

CHAM. Tongue *red* and cracked.

COLCH. Tongue *bright* red.

GELS. Tongue red, raw, painful, inflamed in middle.

HELLEB. Tongue dry and red in typhus, full of vesicles.

HYOS. Tongue red, brown, dry, hard, cracked as if burnt, clean parched.

LACH. Tongue dry, red, cracked at tip; red tip, brown centre.

LYCOP. Tongue dry, red, becomes black and cracked.

MERC. Tongue red and dry; red, with dark spots and burning.

MERC. C. Tongue dry, red, papillæ elevated, strawberry-like.

SANG. Tongue red, feels as if in contact with something hot.

STRAM. Tongue pale red, and in constant motion. (Lycop., helleb.)

TEREB. Tongue smooth, as if deprived of papillæ.

LEAD-COLORED. Also *bryonia*.

4. VIOLENT BURNING ON THE TONGUE. Also

ACON. *Burning*, prickling, tingling. (See alum.)

AGAR. *Burning*, smarting tip.

APIS. *Burning*, rawness, painful stinging blisters on edge of tongue.

ARG. MET. *Burning* blisters on.

ARN. *Burning* and stinging in the back part of throat.

ARUM. *Burning*, painful, cracked.

ASARUM. *Burning sensation* across the tongue.

BROM. *Burning* on UNDER surface of.

CALC. C. At tip. Also calc. ph., carb. an., china, coloc., kali hyd., nat. c., nat. m., nat. sulph., nitrum.

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CHAM. *Burning*, violent, on.
OX. AC. *Burning*, sensitive, red, dry, swollen.
PHOS. AC. *Burning in* the tongue; tongue swollen.
SPIG. *Burning* with blisters. Also *spong*.
LEAD-COLORED TONGUE. Also under *bryon*.

Z. T. MILLER, M.D.

FAUCES, PHARYNX AND ŒSOPHAGUS.

The symptoms of arsenic referring to the fauces, pharynx, and œsophagus are: "dryness and burning in fauces and throat, sensation of constriction, swallowing very difficult and painful, burning when swallowing, food goes down to region of larynx, when it is ejected." "Tonsils inflamed, swollen, burn like fire." "Diphtheritic membrane is dry looking and wrinkled." No allusion is made anywhere in this array of symptoms to the appearance or condition of the throat, aside from the diphtheritic membrane, and it is only by learning the action of arsenic on mucous membranes elsewhere that an idea in regard to it can be gained.

Arsenic attacks the mucous membrane through the blood, and it attacks the membrane without affecting the submucous structures. It causes swelling and inflammation with florid redness of the membrane, which is destroyed, becoming soft and pulpy; leaving the structure underneath unaffected. Supposing, then, that the action of arsenic is the same on the mucous membrane of the throat as elsewhere, we would expect the throat on inspection to present a vivid florid red appearance; not greatly swollen, because the submucous structures are not at all affected, and if the action of the poison in the system should go on to destruction of the membrane, there would be ulceration or diphtheritic membrane as stated.

Aconite has "burning and numbness in the throat, and has dryness as if something had stuck in the throat. It does not have any burning in the mouth as does arsenic, but it has like ars. burning from stomach up through œsophagus to mouth." Such a condition, when arsenic is indicated, would arise from tissue change in the structure of the parts; while with aconite

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it is the result of acute inflammatory processes just established. Both have a dryness in the throat with the burning sensation; under arsenic with sense of constriction and with difficult and painful swallowing. The sensation of numbness is found only under aconite, and is marked, even to insensibility. The tingling or pricking of aconite too usually present with the numbness, serve to distinguish it from arsenic when the burning in stomach and throat are prominent.

Asafœtida, also, has "burning and dryness in œsophagus, burning in fauces;" in which it resembles arsenic without the sensation of constriction which arsenic presents. Like arsenic too it has "burning in mouth," but does not have it in the stomach. The "sensation of a ball rising in the throat," the pulsations in the stomach, and the large accumulation of flatus of asafœtida will serve to distinguish them.

Bovista presents "burning in the throat, sore throat with scratching and burning in the œsophagus, great dryness in throat." Here we have repeated the "dryness and burning in fauces and throat" of arsenic, without its sensation of constriction, but with a scratching and sticking which arsenic does not possess; neither does it have the burning in stomach and mouth of arsenic.

Bromium has "burning sensation in mouth, œsophagus and stomach" due to an inflamed condition. How like arsenic! Yet swelling in the fauces and pharynx, and swollen and inflamed tonsils, are unlike arsenic; it has also a scratching in the throat unlike arsenic.

Cantharis has "burning sensation in throat as if on fire, burning soreness of the throat, which is inflamed." Having too a "burning pain in mouth and violent burning pain in stomach." So far it bears a close resemblance to arsenicum—arsenic has dryness of entire throat; while in cantharis the dryness is confined to the pharynx, and is accompanied by stinging, while in arsenic the dryness is accompanied by soreness and scraping. The constriction present with cantharis is confined to the back part of the throat; with arsenic the constriction is more general, being referred to the throat. The inflammation of cantharis is greater than that of arsenicum, the faucial symptoms especially,

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besides the burning, are more severe; there are swelling, inflammation and ulceration. Both may be indicated in diphtheria with great prostration, the membrane in arsenic looking dry and wrinkled, and with cantharis there are "aphthous ulcers covered with whitish, adherent crusts on both tonsils, throat covered with plastic lymph." Arsenic has thirst for frequent sips of water, and cantharis has intense thirst with disgust for water, because any attempt to swallow it, greatly aggravates the burning and constriction. The urinary symptoms afford a further means of differentiation.

Capsicum very closely resembles cantharis, and there is sufficient similarity to arsenic to consider it here. It has burning in the mouth, throat, and stomach. Whether "throat" means the fauces, pharynx, and œsophagus I cannot ascertain, but presume it does. The burning in the mouth is confined to blisters, which is totally different from the condition causing burning in arsenic, but similar to cantharis. The ulceration in all three remedies is accompanied by burning. The capsicum sore throat is inflamed, dark-red, burning, pressing, both tonsils being inflamed, the left being worst. Its diphtheritic deposit is like that of cantharis, white; unlike the wrinkled membrane of arsenicum. Under capsicum the throat symptoms are all worse between the acts of deglutition. All three remedies have burning in the stomach, and both arsenic and capsicum may have coldness there; but with capsicum the coldness always precedes the burning. There is intense thirst with capsicum, and often drinking causes shuddering. With arsenicum there is thirst, but drinking molests the stomach; with both there are diarrhœa and dysentery, quite different in character, but in such conditions, with arsenic there is renewal of desire for passage from eating or drinking, and with capsicum there is such desire after a drink. There is constriction in the throat in both remedies.

Cocculus has burning in the œsophagus and fauces, dryness and constriction in pharynx, and a paralyzed condition; all of which are similar to arsenicum, the burning, however, does not extend into the mouth or stomach, and is accompanied by a taste of sulphur in the mouth; the dryness lacks the accompanying soreness and scraping, and the choking constriction is

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accompanied by a difficulty in breathing, and an irritable cough. Arsenic has "swallowing very difficult and painful," while cocculus has "pressive pain in tonsils, worse when swallowing saliva than when swallowing food." Then, too, in a general way, the restlessness of arsenic is absent in cocculus, and instead, is entire physical languor, disinclination to make any effort, feels even too weak to talk aloud.

Gelsemium has also "burning in fauces and œsophagus, dryness in fauces, and paralysis of the organs of deglutition," but no feeling of constriction about the parts. There is burning in the œsophagus to the stomach, but there is no involvement of the stomach itself, nor is there any in the mouth; in this it is the same as cocculus. The dryness and burning in fauces are accompanied by inflamed and swollen tonsils, feeling as if the throat were filled up, swallowing is painful as with arsenic, but with the effort there are pains shooting into the ears, the Eustachian tubes being involved. As with both arsenic and cocculus, gelsemium has "paralysis of the organs of deglutition," and like cocculus the tongue is similarly involved, being heavy and unwieldy. We miss in gelsemium any similarity to the restlessness of arsenic. Similar to cocculus, there is heavy, stupid inactivity, both mental and physical, desiring quiet more than anything else.

Mercurius corrosivus has "burning in the mouth extending to the stomach," thus bearing superficially a resemblance to arsenic. The constriction of the throat which is present, under arsenic, is not found under mercurius corrosivus, and instead of the scraping sensation of arsenic, mercurius corrosivus has pricking in the throat as from needles; the dryness of arsenic is also absent; in its stead is profuse salivation, which serves as much as any other symptom to distinguish them. With both drugs swallowing is painful and difficult, but this is especially so with mercurius corrosivus, an attempt even at swallowing causes retching and vomiting. There is no paralysis of the throat with mercurius corrosivus, and the appearance of the throat is entirely dissimilar to that under arsenic; uvula, tonsils and entire throat are greatly inflamed and swollen, of dark-red color, and covered with ulcers.

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Mezereum is very similar to arsenic; it has dry feeling in the throat which occasions difficulty in swallowing; it is not, however, nearly so general and marked as under arsenic, because, referring to the mouth, we find that the saliva is almost always increased, and in the throat there is a sensation as if it were full of mucus posteriorly, which is not relieved by hawking. Mezereum has chilliness of the body, even in bed, accompanied by burning mouth, pharynx, œsophagus, and stomach as with arsenic; however, the burning in the stomach is relieved by eating under mezereum, and we fail to find under mezereum the molestation of the stomach recorded under arsenic after drinking water. Arsenic has a sensation of constriction in the throat; mezereum causes constriction of pharynx; food presses on the part during deglutition. The color of the throat under mezereum is dark-red, under arsenic, florid red.

Phosphorus has "dryness of the throat day and night, so dry it fairly glistens," which is more pronounced than arsenic; it differs too from arsenic in that the mouth is not so affected, there being instead an increase of saliva. It has a scraping like arsenic which is accompanied by rawness, both of which are worse in the evening, but the constriction found under arsenic is not present; there is, however, a spasmodic constriction of the œsophagus at or near the cardiac orifice, which causes food swallowed to be immediately ejected. Arsenic has ejection of food, but it descends no farther than the larynx, and is then cast out. The burning of arsenic is found involving the stomach, and extends to, and includes the mouth; with phosphorus there is burning involving throat and stomach, but not the mouth. The appearance of the throat under both drugs is similar; under phosphorus the mucous membrane is so dry it fairly glistens; with arsenic it is dry and florid red; the dryness is probably most marked in phosphorus. The tonsils may be swollen in both drugs, but with phosphorus the uvula is also involved which is not likely to be the case with arsenic.

Psorinum has burning involving the mouth and throat, how much of the œsophagus is included I cannot learn, but the stomach is free. The burning in the throat is as if it were scalded, and although the burning in the mouth is accompanied

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by dryness as with arsenic, the throat is not so, there being accumulation of mucus, which is tough and hard to dislodge. Constriction is not mentioned under psorinum. The burning in the mouth is made worse from use of warm food, but there is no annoyance from cold food; the same is probably true of the throat, while with arsenic there is no recorded difference, swallowing being very difficult and painful. There are present under psorinum, not found under arsenic, ulcers on the right side with deep-seated pain and sensation as of a lump or plug in the throat.

Veratrum album, which resembles arsenic in so many ways, resembles it in throat symptoms. It has burning in the mouth and throat, but the œsophagus and stomach are not involved. There are also dryness of the throat which the drinking of water cannot remove, sensation of constriction in throat, and scraping in throat. It will be perceived that all these symptoms are counterparts of those of arsenic; but, however, much they may sound like arsenic, a look at the throat will clear up all doubt; arsenic produces a true inflammatory condition with swollen mucous membrane which looks red and angry. The condition under veratrum album arises from involvement of the nerves supplying the part, and there is an absence of all inflammatory conditions.

Veratrum viride causes a true inflammation of these parts. The burning of the mouth is confined to the tongue, which feels scalded; and instead of dryness, there is copious secretion of saliva. There is dryness in the throat like arsenic, but there is likely to be an accompanying hiccough. The burning includes fauces and œsophagus, but a symptom distinguishing it from arsenic is, that there is a constant inclination to swallow. Unlike arsenic there is a sensation of a ball rising into the œsophagus.

JNO. L. FERSON, M.D.

ABDOMEN AND HYPOCHONDRIA.

I. Painful bloatedness in right hypochondrium, with burning pain. Pain in region of liver, increased on pressure. General accompaniments: vomiting of black substances, black stools, burning heat of the skin, very quick pulse, rapid exhaustion, characteristic thirst, anxiousness, and restlessness.

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Aconite. Tension, heaviness, burning in hypochondria, with anxious feeling in præcordia. Inflammatory fever.

Æsculus hip. Constant severe aching from pit of stomach to right lobe of liver. Tenderness in right hypochondrium, or pinching pain with colic; pain through to the back on inspiring.

Aloe. Painfulness in the hypochondria, with chilliness and diarrhœa; painful weakness of the legs. Distension of the hypochondria, better after passing flatus. Burning, uneasiness, pressure and tension in hepatic region, worse on standing, bends forward.

Alumina. Pain and tension in region of liver, as if bruised when stooping, stitches when rising again.

Apis. Violent burning pain under short ribs, both sides; absence of thirst.

Argentum nitricum. Tension as from a band around the hypochondria. Region of liver sensitive to pressure, periodical pains about liver, with nausea, retching, and vomiting of tough phlegm.

Aurum. Burning heat and cutting pain in right hypochondrium; incarcerated flatulence.

Baptisia. Pain in the region of liver from right lateral ligament to gall-bladder. Constant pain over gall-bladder—patient must stir about, yet motion is painful.

Belladonna. Acute pain, with tension in right hypochondrium, worse on pressure, breathing, coughing or jarring; cannot lie upon the right side.

Bryonia. Burning pain in hypochondria, with pain in right shoulder and arm. Hard, dry stools, as if burnt.

Chelidonium. Acute or dull pain and tenderness in region of liver, or pains shooting towards the back. Constant pain under lower inner angle of right shoulder-blade. Sallow, jaundiced complexion.

Chamomilla. Dull, aching pains in region of liver, not aggravated by pressure, motion, and breathing, with tension in hypochondria.

China. Swollen, hard liver, with pain in hepatic region as from subcutaneous ulceration, very sensitive to touch. Gall-stone colic. Gastro-duodenal catarrh.

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Conium. Painful tearing in hepatic region. Liver hard and swollen, cirrhosis. Erratic itching of all parts of the body.

Dioscorea. Dull, heavy, grinding pains, or cutting, squeezing, and twisting pains in region of liver, relieved by stretching the body out. Neuralgia and spasmodic affections of liver and gall-ducts.

Eupatorium perf. Soreness and tension in region of liver; tight clothing is oppressive. Severe aching in back and limbs.

Ferrum. Tightness and sensitiveness in right hypochondriac region; pain in small of back and liver. Liver enlarged and painful to touch. Always better when walking slowly about, although patient is very weak.

Ignatia. Uneasiness, with great distension of hypochondria, pit of stomach, and small of back. Unable to breathe on account of fulness and tension under lower ribs.

Iodium. Region of liver sore to pressure; stitching pain in hepatic region. Cirrhotic liver. Constant desire to change place, without anguish and tossing.

Ipecac. Pinching pain in both hypochondria and in region of stomach. Continuous nausea.

Iris. Pain in right hypochondriac region, worse on motion. Cutting in region of liver. Increase of, then deficiency of bile, with jaundice. Autumnal diarrhœa.

Kali carb. Epigastrium swollen, hard, and sensitive, with pulsations therein; pains in hepatic region shooting down to bladder and testes; cutting, stitching, shooting, darting all over the abdomen.

Kreosotum. Bruised pain in region of liver, with sensation of fulness, as if he had eaten too much; must loosen his clothes.

Lac caninum. Severe burning in right hypochondrium, iliac region and corresponding part of back, extending across the back to the left side of the abdomen, better when on feet, worse when lying down.

Lachesis. Acute pain in the liver, extending toward the stomach; pain as if something had lodged in the right side, with burning and stinging. Cannot bear any pressure about the hypochondria.

Laurocerasus. Sticking pain in liver, with pressure; region

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of liver distended; pain as from subcutaneous ulceration, or as if an abscess would burst. Drink rolls audibly through the œsophagus and intestines.

Leptandra. Dull aching or burning distress in the region of liver, aggravated by drinking cold water. Black, tarry, papescent, profuse, offensive stools.

Lithium carb. Violent pain in hepatic region between ilium and ribs. Pressure and fulness in right hypochondrium. Abdomen feels swollen, as if distended with wind.

Lycopodium. Tension in region of liver which is very sensitive to contact and pressure. Tension as from a hoop, or a cord, marking the attachments of the diaphragm; cannot stretch or stand upright.

Magnesia mur. Pressive pain in liver, when walking or touching it, worse when lying on right side. Liver hard and enlarged.

Mephitis. Rheumatic pain in region of liver.

Mercurius. Inflammation with great tenderness of liver to contact, with jaundice. Characteristic diarrhœa.

Muriatic acid. Pressing and tension in hypochondria. Inclination to slide down in bed.

Natrum mur. Dull, heavy aching and distension about the liver, worse after eating, lessening as digestion advances.

Natrum sulph. Region of liver sensitive to touch, stepping, deep breathing, or sudden jar; aching, piercing pain.

Nux vom. Liver swollen and sensitive, with pressure and stinging; cannot bear the clothes tight; throbbing as from a hepatic abscess. Habitual constipation.

Phosphorus. Enlargement and induration of liver, with subsequent atrophy. Oppression in stomach, unquenchable thirst; abdomen flaccid, with chronic loose bowels.

Podophyllum. Fulness in right hypochondrium; hyperæmia of the liver, with flatulence, pain and soreness; twisting pain in right hypochondrium, with sensation of heat there. The patient is constantly rubbing and stroking the hypochondrium with hands.

Psorinum. Deep, heavy pain in region of liver, worse from pressure, lying on it, coughing, laughing, or on deep inspiration; sharp stinging in pit of stomach.

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Pulsatilla. Darting, tensive pains in hepatic region; sticking pains, especially when walking. Chilliness even in a warm room; frequent attacks of anguish, with greenish and slimy stools; thirstlessness.

Rhus tox. Soreness, as if beaten, in hypochondria.

Secale corn. Acute pains in hepatic region; inflammation and gangrene of liver. Wants to be uncovered.

Sepia. Constant aching in right side of abdomen; aching weight and soreness in right hypochondrium, with distress and aching in right shoulder and scapula. Forehead and conjunctiva yellow, with yellow saddle across the bridge of nose. Functional derangement of liver.

Silicea. Throbbing, ulcerative pain in hepatic region, worse from touch or walking. Hardness, distension and soreness of liver, worse on motion and when lying on right side. Burning or throbbing in pit of stomach.

Theridion. Violent burning pains in hepatic region, worse from touch; retching, bilious vomiting. Mouth and tongue benumbed. Hepatic abscess.

Veratrum alb. Hyperæmia of liver, with gastric catarrh. Great pressure in hepatic region, alternating with vomiting or diarrhœa.

Zincum met. Liver enlarged, hard and sore to touch, with crampy pains, dyspnœa and hypochondriasis, while eating. Feet swollen; vomits bloody phlegm.

II. Stitches in right hypochondrium, extending to the region of the stomach, ending as violent pressure over the whole abdomen.

Aconite. Stitches in right hypochondrium, taking the breath.

Agaricus. Sharp stitches, as from needles in region of liver; dull stitches during breathing.

Aloe. Stitches from liver into chest, obstructing respiration.

Borax. Stitching, pressing, cutting in right hypochondrium, extending downwards across the bowels, followed by diarrhœa.

Bryonia. Transient stitches in right hypochondrium, with pain increased on pressure, especially on deep inspiration.

Calcarea carb. Stitches in hepatic region during or after

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stooping. Tightness of clothing about the hypochondria is unendurable. Distended abdomen, with emaciation and good appetite.

Carbo veg. Stitches and tension in region of liver. Hypochondria painful. Clothing oppresses and is unendurable.

Chamomilla. Stitches in hypochondria, with frequent chilliness, after vexation.

Chelidonium. Stitching and pressive pains in region of liver. Jaundice.

Colocynth. Transient stitches in hepatic region. Characteristic colic.

Conium. Stitches from hepatic region to right side of chest. Induration.

Cyclamen. Stitches in region of liver, with a ball-like distension in the intestines below the liver.

Graphites. Stitches in right hypochondrium. Liver hard. Herpetic constitution.

Hepar. Stitches in region of liver, when walking. Chronic engorgement of liver. Hepatic abscess.

Kali bich. Stitches or dull pain in right hypochondrium, confined to a small spot, with clay-colored stool, metallic taste, and confusion of head.

Kobaltum. Stitching, shooting pain in hepatic region, worse from deep inspiration, with fulness of abdomen, after slight meal, and constant dropping of blood with stool.

Kreosotum. Stitches in region of liver which is very sensitive to contact, with constriction of hypochondria. Cannot tolerate tight clothing.

Magnesia carb. Stitches in hepatic region. Characteristic stools.

Mercurius sol. Stitches in hepatic region, interfering with breathing and eructations. Liver swollen, indurated, sensitive; cannot lie on right side.

Mercurius corr. Stitches in hepatic region, as if in middle of liver.

Natrum mur. Stitches and tension in liver, which is inflamed and swollen. Skin earthy yellow.

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Natrum sulph. Stitches in region of liver and sensitiveness, when walking in the open air.

Nitric acid. Stitches in right hypochondrium. Liver enormously enlarged, with icterus and clay-colored stools.

Nux vomica. Stitches in region of liver, worse from contact or motion. Thirst, red urine, headache.

Oxalic acid. Stitches in liver, relieved by deep breath.

Phosphoric acid. Stitches, heaviness, and burning in one spot in region of liver, during the passage of gall-stones.

Podophyllum. Stitches in right hypochondrium, worse while eating.

Ranunculus bulb. Stitches in region of liver, arresting breathing, extending up into chest. Soreness of hypochondria, worse on touch, as if bruised.

Sepia. Stitches in liver, with pressure downwards.

Spigelia. Stitches in region of diaphragm, especially left side, arresting breathing.

Sulphur. Stitches, swelling and hardness of liver. Chronic hepatitis. Abscess.

Thuya. Stitches in hypochondria, now right, then left.

III. Drawing, stitching pain under left hypochondrium.

Tensive, pressive pain in spleen.

Induration and enlargement of spleen.

Accompaniments: frequent dark or bloody diarrhœic stools, with burning and great debility, etc., or when the disease assumes an intermittent character.

Æthusa. Painful pressing, with burning and stitching pains in left hypochondrium. Violent vomiting of coagulated milk. Spasms, with stupor and delirium.

Aloe. Stitches from spleen into chest, or drawing into the loins.

Apis. Stitching and burning pains in left hypochondrium, extending up into chest. Dryness, but very little thirst.

Berberis. Cramp-like retraction in splenic region, or drawing, tearing in left hypochondrium, with sensation during respiration as if something were torn loose.

Borax. Pressure in left hypochondrium, or cutting in region

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of spleen, on walking rapidly, as if a sharp movable piece were there.

Capsicum. Spleen sensitive, swollen, especially after abuse of quinine.

Carbo veg. Pressing and pinching in region of spleen, or quick, lightning-like stitches, with distended abdomen. Scurvy.

China. Aching-stitching pains in spleen, when walking slowly. Spleen swollen, inflamed, indurated. Oppression of chest and dropsy.

Dioscorea. Sharp pains, aching or digging in left hypochondrium. Pains relieved by stretching out.

Ferrum. Shooting pain in left hypochondrium, or cramp-like sensation in splenic region. Spleen enlarged; after intermittent or abuse of quinine.

Fluoric acid. Stitches in left hypochondrium; pinching in spleen; pressing pain in region of spleen and left arm. Left leg goes to sleep easily; œdema.

Graphites. Burning internally in left hypochondrium, worse when lying on it.

Hydrastis. Sharp pain in region of spleen, with dull pain and burning in stomach and bowels.

Ignatia. Fulness and tension in left hypochondrium; swelling and induration of spleen. Sadness and sighing, with a weak, empty feeling in the pit of stomach.

Iodium. Left hypochondriac region hard and acutely painful to pressure. Enlarged spleen, after intermittent.

Kali bich. Dull heavy pressure or stitches in splenic region. Stitches extending from spleen into lumbar region, worse from motion or pressure.

Kobaltum. Sharp pain in region of spleen, worse when inspiring deeply.

Lachesis. Shooting pain in region of spleen which is very sensitive to pressure. Skin brown near the region of stomach; brown spots on hands.

Lycopodium. Fulness and tensive pressure in left hypochondrium; rumbling of wind in splenic flexure of colon; incarcerated flatulence.

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Natrum carb. Stitches in left hypochondrium, worse after drinking very cold water.

Natrum mur. Stitches and pressure in splenic region. Spleen swollen. Dry tongue, ulcerated corners of mouth; symptoms generally worse at 10 A.M.

Natrum sulph. Stitches in left hypochondrium, while walking in the open air.

Nitric acid. Tension in splenic region; spleen enlarged after yellow fever.

Nux mosch. Stitches in spleen, must bend double; enlarged spleen, with looseness of bowels, abdomen enormously distended; dropsy.

Nux vomica. Pressure in left hypochondrium, from abdominal plethora.

Psorinum. Stitches in spleen; better when standing, worse when moving, and continuing when at rest again. Shortness of breath; dropsy.

Rhododendron. Pain, as from flatulence, in left hypochondrium. Stitches in spleen when walking fast, tension when stooping.

Sanguinaria. Violent stitches in splenic region. Pain in hypochondrium, worse on coughing, better from pressure, and when lying on left side.

Sulphur. Stitches in spleen, worse on deep inspiration, or when walking, with stitches in left side of abdomen, when coughing.

Sulphuric acid. Spleen enlarged, hard and painful; hurts when coughing.

IV. Abdomen, distended and painful.

Aconite. Abdomen swollen, burning hot, and sensitive to pressure. Inflammatory fever.

Aloe. Distension of the abdomen with flatus moving about; worse after eating; abdomen painful, with urging to stool, and passage of only offensive flatus.

Apis. Fulness and distension of abdomen, with soreness to touch or on sneezing. Urine scanty, dark, like coffee-grounds.

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Arnica. Tympanitic distension of abdomen, with hardness and frequent urging to stool.

Apocynum. Abdomen distended and painful. Ascites. Sinking feeling at pit of stomach.

Asafœtida. Great and painful distension of abdomen. Wind colic. Flatus passing upward, none downward.

Baptisia. Fulness and distension, with trembling; feel as if vomiting would relieve; mushy stools. Left iliac region particularly sensitive to touch. (Ileo-cæcal region: ars., merc., phos. ac.)

Baryta carb. Abdomen distended and hard, pot-belliedness. Scrofulous diathesis.

Belladonna. Painfully distended abdomen, very sensitive to touch, cannot bear the least jar of bed; cæcal and peritoneal inflammation. Pains come and go suddenly. Constant moaning.

Borax. Flatulent distension after every meal, with pain in abdomen, as if diarrhœa would set in.

Bryonia. Abdomen distended, hard and very sore; hard swelling around umbilicus. Patient lies perfectly still, does not want to move.

Calcarea carb. Abdomen very much distended and hard; obstructed flatulence. Mesenteric glands enlarged and indurated. Great emaciation, with good appetite. Leuco-phlegmatic.

Cantharis. Distension and tenderness of abdomen. Violent burning thirst, with aversion to all drinks. Characteristic urinary symptoms.

Capsicum. Abdomen distended; flatulence, with suffocative arrest of breathing.

Carbolic acid. Distension of abdomen, with rumbling and rolling of gas.

Carbo veg. Abdomen distended, full to bursting, mostly in the afternoon, with loud rumbling and gurgling in the intestines. Distension aggravated after meals, relieved by passing flatus up or down.

Chamomilla. Abdomen tympanitic and sensitive to touch, distended like a drum. Wind-colic. Flatus passes in small quantities, without relief; improved by applying warm cloth.

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Cina. Abdomen hard and distended, with painful twisting about the navel. Helminthiasis.

China. Abdomen distended, wants to belch. Abdomen as if packed full, not relieved by eructations. Tympanites, especially in the morning.

Colchicum. Great distension of the abdomen, with pain in back. Feeling as if patient had eaten too much, with griping pain. Surface of abdomen hotter than any other part of body.

Colocynth. Abdomen distended, with characteristic colicky pains.

Crotalus. Swelling of the whole abdomen, with intolerance of clothing about epigastric region. Hæmorrhage from all orifices of the body.

Cocculus. Abdomen distended; feels as if full of sharp stones when moving; rumbling in the intestines.

Croton tig. Abdomen full and distended, with colic and writhing around umbilicus. Intermittent diarrhœa, with debility.

Ferrum. Hard and distended abdomen. Emaciation. Chlorotic symptoms.

Graphites. Great distension of abdomen, with hardness. Persons inclined to obesity.

Helleborus. Excessive distension of abdomen; gurgling as if bowels were full of water. Bloated but not painful. General anasarca, acute cases.

Hepar. Abdomen distended and tense, with frequent desire to loosen the clothing. Fermentation in abdomen.

Hyoscyamus. Distension, with pain on pressure; tympanitic distension. Desire to uncover and remain naked.

Kali bich. Tympanites; abdomen feels bloated, with eructations, soon after eating. Chronic, intestinal catarrh. Excessive secretion of mucus.

Kali carb. Fulness, heat and great distension of the abdomen, immediately after eating a little, with discharge of much flatulence. Dropsical swelling, with liver or heart disease. Swelling over the eyelids.

Lachesis. Abdomen distended and hard; hot sensation and painful. Rumbling before diarrhœa. Can bear no pressure, not even of bedclothes.

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Lilium tig. Abdomen sensitive to pressure or jarring; distended, with moving of flatulence. Dragging down of whole abdominal contents.

Lycopodium. Excessive fulness and distension of abdomen from flatus, with tension and pain. Flatulence increased immediately after eating ever so little. Distension, with constipation. Meteoristic distension.

Mancinella. Sensitiveness in abdomen, aggravated after drinking water.

Mercurius. Abdomen hard, distended and painful; rumbling each time after drinking or before every stool. Enteritis with bloody, slimy stool and tenesmus. Typhlitis, with hot swelling in ileo-cæcal region. Peritonitis, with purulent exudation. Aggravation from heat of bed, during perspiration which gives no relief.

Nat. carb. and mur. Hard, bloated and swollen abdomen; heaviness in upper part; accumulation of flatus and loud rumbling. Thirst, drinking often, and much at the time.

Nitric acid. Abdomen distended, with flatulence, very tender; intestinal ulceration and hæmorrhage.

Nux vomica. Pressure and flatulent distension, with rumbling worse after eating; sensation in abdomen, as if all were raw, with distension immediately after drinking.

Nux mosch. Heaviness in upper part of abdomen, and distension as if from flatulence. Rolling and grumbling in abdomen.

Opium. Hard, bloated, tympanitic abdomen. Anti-peristaltic motion, with belching and vomiting. Bowels seemed absolutely closed, but with constant urging to defecate or urinate.

Phosphorus. Abdomen distended; rolling and gurgling from flatulence, though much of it is passed; rumbling painful, worse during and after drinking; very offensive flatus passes. Abdomen very sore to touch, especially below the navel, if pressed upon.

Phosphoric acid. Meteoristic distension of abdomen; rumbling and gurgling, with whitish, watery, painless diarrhœa.

Pulsatilla. Fulness and distension of abdomen and stomach, with painful sensitiveness; shifting of flatus, with diarrhœa, pinching and grasping pains.

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Rhus. Distension of abdomen, especially in the region of navel, with sensation as if beaten or with severe pinching, painful as if from pent-up gas; offensive flatus. Typhoid symptoms.

Sanguinaria. Flatulent distension of abdomen in the evening, with escape of flatus from vagina.

Secale. Abdomen distended and tympanitic; painful sensitiveness, with nausea and confusion of head.

Sepia. Abdomen distended and sensitive, with colic recurring toward evening, and rumbling, especially after eating. Climacteric disorders.

Silicea. Distended, hard, hot abdomen, with colic and emission of very offensive flatus. Scrofulous diathesis.

Sulphur. Abdomen distended and hard, with much flatulence, painful; swollen as if from pent-up gas. Rolling and grumbling in bowels.

Thuja. Abdomen enlarged and puffed; protrudes here and there as from the arm of a fœtus; sensation as if something alive were in abdomen, without pain.

Valeriana. Hard, bloated abdomen, twisting colic. Hysteria.

Veratrum alb. Distension, with hardness of abdomen, which is very sensitive to touch; rumbling in abdomen, as if there would be diarrhœa.

V. Violent burning pains, with intolerable anguish.

Aconite. Burning pains in abdomen, worse from least pressure and lying on right side.

Apis. Burning and stinging in bowels.

Belladonna. Heat and burning in abdomen, with shooting pains.

Cantharis. Violent, burning pain through the whole intestinal tract. Dysuria.

Crotalus. Burning pain in abdomen; yellow color of whole body.

Lachesis. Burning like fire in hypogastric and lumbar regions.

Nitric acid. Burning over whole abdomen; worse 2 to 3 P.M.

Podophyllum. Heat in bowels, with inclination to stool.

Sabadilla. Burning in bowels; fever without thirst.

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Secale. Burning in abdomen, with aversion to heat or to being covered.

Veratrum alb. Burning in abdomen, as from hot coals, with violent thirst for large quantities of very cold water and acid drinks.

VI. Cutting pain in abdomen.

Aconite. Cutting and darting pains in bowels, so violent that he screams, tosses about and is almost beside himself.

Antimonium crud. Violent cutting pain, as if bowels would be cut to pieces, with watery diarrhœa and milky white tongue.

Belladonna. Violent cutting pressure in abdomen, now here, now there.

Bryonia. Cutting in bowels; worse from least motion.

Cantharis. Cutting pains through the bowels. Violent burning thirst, with aversion to all drinks.

Chelidonium. Cutting or griping pains in abdomen, which is hard and distended.

Colocynthis. Violent cutting, constrictive or spasmodic pains; relief by bending double.

Cuprum. Cutting and lacerating in bowels; abdomen drawn in.

Dioscorea. Sharp, cutting, twisting pains, relieved by stretching out.

Ipecac. With every movement, cutting pain around umbilicus, almost constantly running from left to right. Constant nausea.

Kali carb. Violent cutting pain all over abdomen. Spasmodic affections.

Lachesis. Cutting in right side of abdomen, causing fainting attacks.

Magnesia carb. Cutting, griping and rumbling in whole abdomen, followed by thin, green stools, without tenesmus.

Mercurius. Cutting, stabbing pains in abdomen, with chilliness. Dysentery, enteritis and peritonitis.

Nux vomica. Cutting pains as from stone, with periodical colic before breakfast and after meals. Pain shooting upwards.

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Plumbum. Cutting pains, with restless tossing, better from rubbing or hard pressure. Abdomen retracted.

Pulsatilla. Cutting and dragging pains in hypogastric region around the loins, making her feel faint.

Rheum. Violent cutting colic, forcing one to bend double. On pressure, sensation as if everything were sore and bruised. Sour smelling diarrhœa, with great urging.

Ranunculus. Cutting or pinching colic. Abdomen sore on pressure, as if bruised and ulcerated.

Rhus. Cutting, tearing and pinching colic; worse after eating, better after stool.

Sabadilla. Cutting in bowels as with knives; pain in abdomen, as if caused by worms.

Sanguinaria. Cutting belly-ache from right to left iliac fossa, thence to rectum.

Spigelia. Cutting colic at the navel. Spasmodic and vermicular affections.

Staphisagria. Spasmodic cutting colic in abdomen; worse after eating or drinking. Sensation as if abdomen would drop, wants to hold it up.

Veratrum alb. Cutting, twisting colic, with violent nausea and vomiting. Intestines feel as if tied in knots (as if had become twisted, *ars.*).

CHARLES GANGLOFF, M.D.

STOOL AND ANUS.

One of the most characteristic and striking enteric symptoms of *arsenicum album*, as recognized by the *medical profession*, is where the patient complains of a weak, sinking sensation in the pit of the stomach, relieved by eating, yet so soon as food or drink is taken, urging to stool and diarrhœa immediately supervene. In this particular the drug is similar in its action to cinchona and ferrum.

The stool symptoms characteristic of *arsenicum album* are undigested, slimy, and bloody, and are attended with violent tenesmus and burning in the rectum. If this condition of affairs goes on, the stools become brownish or blackish, and horribly

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offensive; frequent, scanty, and corrosive; painless, watery stools, showing that it is indicated in most serious cases of enteritis and dysentery.

The exciting causes for these various sets of symptoms are sudden chilling of the stomach with ice-water or ice-cream; alcoholic drinks in excess; certain poisons, as sausage-meat that has spoiled; rancid fat; spoiled butter, or fat that has undergone decomposition; and lobster-salad at certain seasons of the year; furthermore, suitable in all cases of poisoning from decayed or morbid animal matter, whether by inoculation, inhalation, or ingesta. Especially suitable in all cases of bowel complaint arising from dissecting or post-mortem wounds. In this respect similar to *baptisia tinctoria.*

Baptisia tinctoria, given in five (5) drop doses, at intervals of an hour or two hours, in all cases of decomposed animal poisoning, will bring about the desired effect much more rapidly than any other one remedy in use. The diarrhœic symptoms of *baptisia tinctoria* are characteristic of those found under *arsenicum album*, with the exception that they are not aggravated by eating or drinking, and lack the leading feature as well—the nervous restlessness, with rapid emaciation and peculiar thirst. *Arsenicum album* also excites intestinal disease which is almost identical with *cholera Asiatica.* Even the organic growths of cholera are found in the alvine discharges from the *arsenicum album* poisoning.

Do not conclude from this that *arsenicum album* must be the remedy for cholera Asiatica. It is only the remedy when we have the following symptoms: Intense vomiting and purging, the stools being not so much like rice-water as they are brownish-yellow, profuse, and offensive. The vomited matters are green, yellow, and bilious.

There is burning thirst, with the intense agony which belongs to *arsenicum album.* Following this condition, we have external coldness of the extremities, and the surface of the body is as cold as ice, but internally the patient feels as if full of fire.

Veratrum album is somewhat similar to *arsenicum album* in cholera morbus. The *arsenicum album* patient has not so copious a stool as the *veratrum album* patient. The cold sweat on the

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forehead is more marked in the veratrum album case. *Arsenicum album* is also useful in cholera infantum. It is indicated by many of the symptoms that have already been enumerated. The symptoms of the bowels are, undigested stools, diarrhœa, which is provoked just as soon as the child begins to eat or drink, worse after midnight, between the hours of 1 and 3 A.M., also in the morning after rising (particularly the restlessness, diarrhœa), and rapid emaciation.

It stands in close relation to *nux vomica* and *sulphur* in atrophy of infants, providing the diarrhœa is present in a case which would call for *nux vomica* or *sulphur* were constipation present.

In far-advanced cases, the resemblance is not to these remedies but to cinchona and *argentum nitricum.*

Argentum nitricum has slimy, greenish stools, with excessive flatulence, worse at night. Although both remedies have restlessness, it is not the same in each case. *Arsenicum album* has a restless desire to change places, now sitting now standing. The restlessnesss of *argentum nitricum* is purely nervous; the patient has difficulty in breathing, with long sighs.

Carbo veg. is somewhat similar to *arsenicum album* in intestinal affections arising from chilling the stomach by taking freely of cold substances.

It has, perhaps, less of the distinctive restless tossing about, but at the same time it may have a nervous, irritable, anxious state without tossing about. *Carbo veg.* is the remedy as well as *arsenicum album*, when rancid fat has excited gastro-enteric disorders.

Secale cornutum is very similar to *arsenicum album* in many of its symptoms. The two drugs are complementary. They agree well one with the other in bowel complaints. Arsenicum album may be distinguished from *secale cornutum* by these few symptoms: The movements in *secale cornutum* are copious, and come in spurts. *Secale cornutum* has not the same restlessness that belongs to *arsenicum album.*

Secale cornutum has a great many characteristics in common with *arsenicum album.* It has the prostration and thirst of *arsenicum album.* A distinction between the remedies can be easily

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made out by the effect of heat and cold. The *arsenicum album* patient is better from heat and aggravated by cold. *Secale cornutum* patient is just the reverse; does not wish to be covered though feeling cold.

Arsenicum album has autumnal diarrhœa, with pinching pain and tendency to run into cholera or dysentery, pulse frequent in the morning and slow in the evening. There is reason to fear that, as routine is easier than study, arsenicum album may have accomplished more harm than good in the hands of homœopathic practitioners. No remedy has been more frequently given in acute affections of the bowels, while it is not the most frequently indicated, and it is not a remedy to be unwisely used.

The symptoms which most clearly distinguish it from other remedies with a similar fatality, are the characteristic thirst and restlessness. These two must be present as a general rule. The mucous stools are not usually offensive, but the watery ones are very much so, and often painless.

J. H. THOMPSON, M.D.

URINARY ORGANS.

The first symptom in order and in importance is, "*Burning in the urethra during micturition.*"

Cannabis sativa has nearly the same symptom, "Burning, smarting in the urethra, from the meatus backward; posteriorly stitching while urinating; burning while urinating, but *especially just after.*"

In Hering's "Guiding Symptoms," it is given that with arsenicum the burning pain is felt especially at the *commencement of urinating*, which would distinguish it from cannabis sativa, which has the burning pain especially *just after.* Then again, with *can. sat.* we have, "urethra feels inflamed and sore to touch along its whole length, and during erection tensive pain." No such symptoms with arsenicum. We would find, I think, that the condition produced by can. sat. is a urethritis, and that produced by arsenicum, a cystitis, and with both we have the burning on urinating; a correct diagnosis of our case would here aid in making a correct prescription.

Cantharis is another remedy having the symptom of "burn-

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ing, cutting pains in the urethra before, during, and after urination." Now, while we have seen that with arsenicum the burning pain is especially at the commencement of urinating, and of the can. sat. especially just after urinating, we now see that with cantharis it is before and after, and also during urinating; and again, that with cantharis, and most characteristic of all, is that "the urine passes drop by drop," or "*guttatum*," as Helmuth would say. And as we have considered the pathological condition produced (and, of course, cured) by arsen. to be a cystitis, and that of can. sat. to be a urethritis, we would consider that cantharis produces both these conditions. Farrington says you will find it indicated in acute cystitis more frequently than all other remedies put together.

The next symptom of arsen. is "involuntary micturition; the urine flowed from her before she was able to reach the chamber." "Involuntary emission of urine at night when sleeping."

Causticum has, in the highest degree, "involuntary passage of urine at night when sleeping; also, when coughing, sneezing, or blowing the nose."

Belladonna and hyoscyamus, also, are valuable remedies for involuntary micturition; the former we generally prefer for the nocturnal enuresis of children, and the latter for the involuntary urination of typhoids, where we would differentiate from arsen. by the other symptoms of the case, though we have oftener found arsen. useful for retention of urine in typhoids.

"Urine scanty; passed with difficulty; burning during emission," is the next symptom of arsen.

Aconite has "painful, anxious urging to urinate; micturition painful, difficult, drop by drop; urine scanty, fiery, scalding hot, red or dark-colored."

Apis has "burning soreness when urinating; frequent desire with passage of only a few drops; urine scanty and high-colored."

Now, these three remedies, arsen., acon., and apis, might be differentiated thus. With arsen. there is thirst for frequent small drinks of water; with acon. there is thirst for frequent copious drinks; with apis there is no thirst.

"Retention of urine, as if the bladder were paralyzed," is an-

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other prominent arsenic symptom. "The bladder is greatly distended and paralyzed." "Atony of the bladder in old persons." "Atony of bladder, no desire to urinate and no power to do so; seems to have lost all control over the power to emit, especially after parturition." Clarence M. Conant, M.D., says, in the *Hahnemannian Monthly*, February, 1888: "It (arsenicum) is my 'therapeutic catheter.' If, after labor, a woman does not urinate within five or six hours, she gets arsen. 200, and rarely fails to respond promptly. This, especially, if there be no desire or discomfort bred of the retention. Urging will call for causticum, hyos., canth., or nux vomica, in this order."

Opium is a valuable remedy for retention of urine, either from paralysis of the fundus of the bladder or spasm of the sphincter; the bladder is full to over-distension, and no desire to void it; the patient is drowsy and stupid. Nux vom., on the contrary, has a desire to void urine all the time, with only a little at each effort, with much pain. The patient is impatient and irritable, distressed and distressing.

Acon. "Retention or suppression of urine, with pressure in the bladder, or stitches in the region of the kidneys; retention from cold, especially in children, with much crying and restlessness."

Stram. "Kidneys secrete less or none, in acute diseases, especially of children. Urine suppressed, especially in cerebral diseases."

Hyos. "Micturition difficult, from spasmodic or inflammatory condition of neck of bladder. Urine scanty, retained or suppressed."

The urine of arsenicum is dark brown, dark yellow, turbid; contains sediment of red sand; is mixed with blood and pus; albuminous.

Red sand in the urine is always suggestive of lycop., which has the symptom red sand on the diaper, but before passing water the child screams with pain.

Sarsaparilla has sand in the urine or on the diaper, and the child screams before *and while* passing it. (Lycop., *before* passing.)

Phosphorus has brick-dust sediment in the urine, and varie-

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gated cuticle on the surface. Phos., like arsen. and opium, has also retention of urine after labor.

Red sandy sediment in the urine is a symptom found under arnica, china, and natrum mur., in addition to those already mentioned, viz: Arsen., lycop., sars., and phos. Urine mixed with pus and blood, while very characteristic of arsenicum, also suggests cantharis, terebinthina, millefolium and chimaphila. With the latter remedy I have succeeded in curing several cases of chronic vesical catarrh, where the prominent, and I might say only, symptom was the bloody purulent urine, and frequent micturition.

In the selection of cantharis for bloody urine, or, in fact, for any of the other conditions mentioned in this paper, we will be guided by what is given in Cowperthwaite as the chief characteristic of the drug, viz.: its constant urging to urinate, and violent cutting, burning pains before, during and after the discharge.

It is indicated in hæmaturia of inflammatory origin.

Terebinthina has smoky turbid urine depositing a sediment like coffee-grounds. The sediment consists of disintegrated blood corpuscles. It is often indicated in dropsy after scarlatina; with the urine there is dyspnœa, the patient must be propped up in bed. There is great drowsiness, and the tongue is dry and glossy.

Lachesis is called for in hæmaturia when the symptoms give evidence of blood degeneration, as in low fevers; there is the characteristic deposit of disintegrated blood cells of fibrin, etc., giving the appearance of charred straw. In albuminuria after scarlatina when the urine is black or contains black spots. This spotted appearance of the urine is a symptom also of helleborus, which is to be distinguished by the sensorial apathy, muscular weakness, pale puffed face, and jelly-like mucous diarrhœa, which accompany its dropsy. The patient may breathe better when lying down, which is the converse of arsenicum and lachesis.

Digitalis has blackish, scanty, turbid urine, faintness from weak heart, with bluish face. Suffocative constriction, as if the internal parts of the chest were grown together. Digitalis has also sinking or faintness at the stomach, as if life were becoming extinct.

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Apis will be called for in post-scarlatinal dropsy, with scanty albuminous urine without blood, thirstlessness, pale waxen skin, and an eruption here and there resembling nettle-rash, red pimples, or an erysipelatous rosy appearance of the anasarcous limbs.

Arsenicum is called for when the urine looks like dark dung-water; albumin and renal casts are abundant. The dyspnœa is noticed more when the patient attempts to lie down in the evening, and again, arousing him after midnight, the dyspnœa is relieved by the expectoration of mucus. In lachesis the dyspnœa is worse, when, after lying down, he drops off to sleep, relief follows the hawking or coughing up of a small amount of thick, adherent mucus, and there is more annoyance from the contact of the clothing than there is with arsenicum, which, however, has present the characteristic restlessness and agony of the drug. The œdema is more or less general, beginning with puffiness of the eyes and swelling of the feet, and ending with general anasarca. The skin is cool and clammy, while internally the patients are burning hot. Little blisters appear on the legs and these burst, and serum oozes from the œdematous limbs. The skin is tense and has a palish waxen hue. (Apis, erysipelatous, rosy appearance of the œdematous limbs.) Exhausting diarrhœa is apt to be present in the arsenicum case, and there is also very apt to be a burning thirst with intolerance of the stomach for water.

W. J. MARTIN, M.D.

FEMALE GENITAL ORGANS.

1. Drawing, stitching pains from the region of the ovary to the thigh, which feels numb and lame—worse from motion, bending, or sitting. Apis, lachesis, lycopodium, belladonna, lilium tigrinum, actea racemosa, cactus grandiflora, palladium.

2. Scirrhus uteri, where the pains are violent and burning, and there is extreme dryness of the vagina. After ulceration has set in, the discharges are fœtid, black, or brownish and ichorous—suited to the later stages. Carbo animalis, lycopodium, kreosote, conium, sepia.

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3. Menorrhagia in feeble cachectic females. Hæmorrhages of a low type—dependent on some degeneration of the organ. Carbo vegetabilis, china, ammonium carbonicum, calcarea carbonica, nux vomica.

4. Leucorrhœa, acrid, thick, yellow; feels it dropping out while she is standing or emitting flatus. In women who are pale and waxy, constantly chilly. Chronic leucorrhœa of old women. Carbo vegetabilis, niccolum, natrum carbonicum, magnesia muriaticum, borax, bovista, kreosote, sepia, aluminum, iodium, platina, zincum.

1. Drawing, stitching pains from the region of the ovary to the thigh, which feels numb and lame—worse from motion, bending or sitting.

Apis and *Lachesis* have similar pains, but both run from the left to the right ovary. In apis the pain is more severe in the *right* side, and is felt worse when stretching. Accompanying it is a pain in the left pectoral region and cough. *Arsenicum* affects the right ovary most, but there is a very marked burning with restlessness, and a *constant desire to move the feet*, which gives temporary relief.

Under *lycopodium* the pains begin on the right side and go to the left—a *cutting* pain, which is *relieved by urinating*.

Belladonna causes severe pains in the right ovary, coming and going suddenly and accompanied with enlargment of the ovary.

Lilium tigrinum has stinging, sharp or grasping pains in the left ovary, or going from the *left to the right*. This is generally accompanied with a sharp pain under the left mamma.

Actea racemosa also has this last symptom, but the ovarian pains shoot *upward*.

In cactus grand. is a remedy which is invaluable where the ovarian pain is intense, becomes unbearable, and extends to both the thighs; *recurring at the same time each succeeding day*.

Palladium is very useful in ovarian troubles; there are soreness and shooting pains from the navel to the pelvis.

2. Scirrhus uteri, where the pains are violent and burning, and there is extreme dryness of the vagina. Then after ulceration has set in, the discharge is fœtid, black or brownish, and

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ichorous. It is suited to the latter stages, and very often gives nights of rest and comfort, not followed by the depressing state which succeeds the use of morphia. In these cases arsenicum 30 will do more good than arsenicum 3x.

Carbo animalis is often useful in scirrhus uteri, with pressive pains in the loins and groin, and especially where there are pronounced gastric disturbances.

Lycopodium will sometimes relieve this trouble; there are tearing stitches, a bloody discharge, physometra and nymphomania.

Kreosote. Pain in the back precedes a discharge of dark coagulated blood, or of a pungent, bloody, ichorous discharge.

Conium. Burning stitches, nausea, vomiting, sadness. Mammæ relaxed, except at the menstrual periods when they swell, and become sore and painful.

Sepia. Lancinating pains from the uterus to the umbilicus. Putrid excoriating discharge from the vagina.

3. Menorrhagia in feeble cachectic females. Hæmorrhages of a low type, dependent on some degeneration of the organ.

Carbo vegetabilis has the same symptom, but here the mental symptoms will differentiate. In the arsenic patient you have irritability of fibre and mind, while carbo veg. is a torpid, sluggish remedy, with none of the arsenicum tossing about, anxiety, etc.

China is a remedy closely allied to both of these, but distinct in that the system is not cachectic, the debility is due to a *recent* anæmic condition.

Ammonicum carbonicum produces a scorbutic condition, but this remedy is to be used in patients whose trouble is of long standing. Then, too, the blood is dark and fluid, the muscles soft and flabby, and a hectic form of fever exists.

In calcarea carbonica the patient is of an entirely different type.

Nux vomica may come in here, but the system is in a comparatively healthy state.

4. Leucorrhœa, acrid, thick, yellow; feels it dropping out while she is standing or emitting flatus. In women who are pale and waxy, constantly chilly. *Chronic* leucorrhœa of old women.

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Carbo vegetabilis has a very foul leucorrhœa, worse in the morning, very acrid. Pruritus of the genitals and anus, a leucorrhœal discharge immediately after micturition.

Niccolum has a leucorrhœa worse after urination, profuse and watery.

Natrum carbonicum. Leucorrhœa, yellowish, putrid; *ceasing* after urination.

Magnesia muriatica. A leucorrhœa after every stool (give it in the 200), sometimes preceded by uterine spasms, and at times followed by a discharge of blood.

Borax. A thick discharge escaping, with a sensation as of warm water passing over the parts. It comes on midway between the menses. Sterility.

Bovista. Leucorrhœa after the menses, flowing only at night.

Kreosote. Menses and leucorrhœa, both inclined to be intermittent.

Sepia. Milky leucorrhœa, only in the daytime; coming before the menses.

Aluminum. Very profuse, acrid; relieved by cold washes (ars. by warm), worse every other day.

Iodium. Has a very acrid discharge, burns wherever it touches, aggravated during the menses.

Platina. Albuminous discharge, only in the daytime. Great voluptuousness.

Zincum. All leucorrhœal symptoms disappear with the appearance of the menstrual flow.

J. Richey Horner, A.M., M.D.

Respiratory Organs.

I. Voice weak, trembling, uneven, hoarse.—*Caust.*, *Phos.*

II. Cough excited by smoky sensation, as from vapors of sulphur. Dry, spasmodic, suffocative night cough, as from sulphur. —*Cinch.* Hollow, spasmodic cough < evening, as from dust. —*Ignat.* Dry cough, from irritation in trachea.—*Lycop.*

III. Cough caused by constant titillation in larynx. Short cough from tickling, with constriction of chest.—*Amm. carb.*

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Dry cough from tickling < evening and before midnight.—*Rhus.* Dry, incessant cough from tickling in throat pit.—*Rumex.*

IV. Cough, with frothy expectoration like beaten white of egg. Cough < morning, with raising of small white lump.—*Alum.* Cough, with copious, frothy expectoration.—*Ant. tart.*

V. Difficult breathing, with great anguish; must spring out of bed < midnight, with constriction of chest. Dyspnœa, with pains in chest > bending forward.—*Asclep. tub.* Dyspnœa, with wheezing, weight and præcordial anxiety.—*Ipecac.* Difficult breathing, with sensation of icy-cold air in lungs.—*Corall. rub.*

VI. Loss of breath immediately on lying down. Arrest of breathing, with spasms of chest on lying down.—*Hyos.* Cough dry, spasmodic < lying down during day or night.—*Conium.* Hacking cough, with loss of breath < lying down and evening.—*Sepia.*

VII. Oppression, caused by stormy weather and heavy air. Oppression, with accumulation of mucus < wet weather.—*Dulcam.*

VIII. Oppression of breathing, on walking fast or ascending a height. Oppression of chest when walking fast or ascending.—*Acon.* Oppressed breathing on ascending stairs < night.—*Kali nit.* Shortness of breath on ascending or walking.—*Merc.*

IX. Constriction of chest, with anxiety and restlessness. Chest feels constricted, better from straightening up.—*Alumina.* Contractive tension right side of chest.—*Cocc. ind.* Tight feeling across the chest, as from running.—*Hyos.* Spasmodic constriction of the chest.—*Ignat.* Constrictive tension in chest, with burning soreness.—*Phos.* Tension in intercostal muscles, with tingling.—*Rhus tox.*

X. Catarrh on chest, with great suffocation and agony. Suffocative catarrh of old people, with burning.—*Hydras.*

XI. Stitches in upper right chest. Stitches in upper left chest.—*Sulph.* Stitches in chest on taking long breath.—*Bryon.*

XII. Expectoration generally frothy, may be thick yellow—*Kali bi.*—green, bitter, salty, or mucus streaked with blood.

WM. D. KING, M.D.

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Effects of Arsenicum upon the Heart.

Arsenic abolishes its contractility, and often inflames its tissue. The feebleness of the heart so produced is probably the cause of the general prostration it produces. It may be used in dilatation and valvular mischief. It relieves pain, palpitation and dyspnœa, and controls the anasarca due to disease of the central organ.

Endocarditis and hypertrophy, also granular degeneration, are the structural changes enumerated as being caused by it.

Anguish in the præcordia, stitching and sore pains there when coughing; pain under the præcordia restricting respiration; palpitation; about 3 A.M. an irregular, but very violent, palpitation, which seems to him audible, with great anguish; palpitation much worse while lying on the back.

Pathologico-anatomical examination shows the heart to be "lax and not overfilled with blood." In the interior of the heart, and especially on the columnæ carneæ and upon the valves of the ventricles, particularly those of the left, is frequently perceived a redness spread over a greater or less extent; in most cases small, red spots, penetrating into the fleshy substance to the depth of one or more lines. The pericardium generally contains a little serum. This from Orfila, who believed the changes observed to be due to endocarditis; Christison and Flandin, toxicologists, denied the correctness of Orfila's conclusions. Whether a true endocarditis results from its poison or not, the fact seems established that carditis and hypertrophy, with granular degeneration, are structural changes which place arsenic in the front rank of heart remedies.

The indications for arsenic are dyspnœa, feeling of constriction across the chest, palpitation, anxiety, sense of suffocation; irregularity and intermission of the pulse, which is jerking and rather hard; burning distress in the chest and region of the heart; dry, barking, fatiguing cough; immediately after coughing the breath becomes very short, as if the chest were constricted.

We now come to a consideration of Arsenicum according to the schema laid down in Cowperthwaite, Hering, and Lippe.

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As found in *Cowperthwaite* we have—

Violent palpitation of the heart, especially at night, visible and audible to the patient, with anguish. Pulse accelerated; irritable; quick and small; quick, weak and irregular; weak, scarcely perceptible. Angina pectoris; sudden tightness above the heart; agonizing præcordial pain; anxiety, dyspnœa, etc.

Lippe gives but one symptom directly referable to the heart, viz., palpitation of the heart at night, with great anguish. Many other symptoms, as oppressed, labored breathing, when ascending; in cold air; turning in bed. Constriction of chest, with anguish, worse moving. Suffocative spells when lying down, etc., are so mixed up with symptoms directly pulmonary as to make it uncertain whether they are attributable to heart disease or not. It matters very little, however; the selection of the remedy does not require it.

Hering.—Palpitation; after suppressed foot-sweat or herpes, with small, irregular pulse; strong, visible and audible at night. Heart beats more rapidly and strong when lying on the back. Pulse: accelerated, quick and small, quick and weak, rapid and weak; small, very frequent and irregular, sometimes imperceptible; threadlike. Palpitation of the heart and tremulous weakness, after stool. Pulsations through the whole body.

In noting comparisons and differentiations we first notice—

Æsc. hip., which feels the *pulsations all over the body*, with a dull aching, *burning*, in the cardiac region, lameness and weariness in the back (piles); faintness at the stomach. Arsenic's aggravation at night with the anguish decides.

Amm. c. has *audible palpitation* with attacks of *great anxiety*, as if dying; cold sweat, etc.

Anacardium. Beating in the bloodvessels, with *rheumatic affections of the heart and pericardium.*

Arg. nit. has *burning* feeling in region of heart, worse when noticing. Neither *Cowperthwaite*, *Lippe* or *Hering* speak of *burning* in the region of the heart; I have, however, relieved such a symptom when there seemed to be no stomach trouble, but would be brought on by exhaustion, by *ars.* 200.

Arg. met. has a twitching of the whole cardiac muscle, especially *while lying upon the back.*

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Badiaga. Nervous palpitation, *cardiac debility.* Palpitation from any elating thought, with a fluttering and vibrating upon the slightest emotion of the mind. The *heart is both heard and felt* to pulsate at night from chest up to the neck.

Bromine. *Hypertrophy*, especially young growing persons. Violent *palpitation at night*, can't lie on the left side (cactus). (*Better* lying on *left side.—Lil. tig.*)

Bryonia. *Pericarditis*, stitches, violent beating from *repercussion of measles.*

Cactus. *Peri-* and *endocarditis.* Sense of *constriction* of the *heart* (*arsenic*, the *chest*), *dyspnæa*, *suffocation*, fainting, cold sweat. *Palpitation* when walking, and at night *when lying on the left side.* (Brom.)

CALABAR (physos.) also causes *pulsations through the whole body*, but particularly in the chest, each beat distinctly perceptible in the chest and temples.

CALCAREA CARB. Palpitation from *suppressed eruptions* and pimples on the face. Tremulous palpitation, with *anguish*, *worse at night*, after meals, and *ascending.*

CARBOLIC ACID has fearful beating of heart, *especially at night.*

CHLORATUM. *Dilatation of the heart;* a weakened heart, with *tightness of the chest.*

FERRUM. Pseudo-plethora, with *hard*, *strong beating* of the heart and *throbbing in all the bloodvessels; restless*, must *walk slowly.*

GRAPH. *Strong pulsation of blood in the whole body*, increased by every motion; tremulous sensation through the whole body.

IODINE. Palpitation is *better* while *lying* perfectly quiet *upon the back.* Ars., *worse.*

NAT. MUR. *Pulsations shake the body;* fluttering, weak, faint, *worse lying down.*

NUX VOM. has *dilatation* and *weakened heart*, with dyspeptic symptoms. Nausea, inclination to vomit.

PHOSPHORUS. *Dilatation*, fatty degeneration, *tightness across* the *chest.*

RUMEX C. Aching in the heart with *throbbing* of carotids (bell., tabac.), *and through the body*, shaking the bed; dyspnœa, *worse lying.* *Burning* in *region* of the *heart.* Dry cough.

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SPIGELIA. *Audible beating of the heart*, with pain through to the back.

TARENT. Violent *throbbing* of *heart and arteries.*

VERAT. ALB. *Violent, visible, anxious palpitation*, with fainting. Pulse slower than the heart.

ZINCUM. Violent *pulsations in the bloodvessels* during the heat.

A résumé of these indications yields:

Pulsations all over the body. Ars.; æsc. hip.; anac.; bad.; coloc.; calabar; ferrum; graph.; kreos.; lilium tig.; nat. m.; rumex c.; tarent.; zinc.

Burning in the cardiac region. Ars.; æsc. hip.; arg. nit.: rumex c.

Audible beating of heart. Ars.; amm. c.; spig.; thuya.

Cannot lie on the left side. Bromine; cactus; baryta c.; kali bi.

Better lying on left side. Lil. tig.

Worse lying on either side. Lil. tig.

Worse lying upon the back. Arg. met; ars.

Better lying perfectly quiet on the back. Iodine; kali bi.

Worse lying down. Nat. m.

Worse at night. Ars.; bad.; brom; cact. g.; calc. c.; carb. ac.

Worse when noticing. Arg. n.; baryta c.

Tremulous weakness with palpitation *after the stool* is also found under *conium;* but conium is relieved by going into the open air, while *ars.* is generally averse to open air, and the weakness obliges him to lie down. The stool of *ars.*, *thick, dark green mucus*, or *dark*, or *black watery fluid;* is quite different from *conium*, which is *liquid, fecal, mingled with hard lumps*, watery, undigested. The *burning* is more marked under ars.

Tightness across the chest is found under chloratum phos.

Constriction of the heart. Cactus g.; lil. tig.; tarent.; iod.

Palpitation after suppressed foot-sweat or herpes, in addition to ars., is caust., lach, sulphur, *bry.*, calc. c.

In angina pectoris. Tabac. compares by having palpitation at night, and *tightness across the chest*, worse *lying on the left side;* goes off when turning to the right. Violent beating of heart and carotids (bell., rumex c.).

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Heart heard and felt to pulsate from chest up to neck.—*Badiaga.*

Heart beats distinctly, perceptible in the chest and temples. —*Calabar.*

Z. T. MILLER, M.D.

SYMPTOMS OF THE RESPIRATORY ORGANS.

There is no one remedy in the entire Materia Medica that will yield more brilliant results in all stages, especially the advanced stage, of affections of the respiratory organs, from the incipient form of rapid emaciation to the more advanced stages or even fully developed phthisis, than arsenicum. Many cases of incipient phthisis and not a few in the advanced stages, attended with alarming symptoms, have been permanently cured with this grand antipsoric of Hahnemann. But to attain this result, there also are few remedies which must be used with greater caution. Here it is absolutely necessary that the direction of Hahnemann as to dose and repetition must be carefully followed out, if we wish to avoid most of all complications or serious aggravations. We must guard against too frequent administration of this drug in all acute cases of phthisis pulmonalis, as it is not a remedy usually called for in the beginning of diseases. The tendency of the symptoms is deathward. If you give this drug to some in a disease which tends deathward, you may precipitate the result which you are anxious to avoid. Now for the inflammation and fever of arsenicum, depending on a diseased condition of the respiratory organs.

Arsenicum alters the blood. It is useful, as we shall learn later on, in low types of phthisis pulmonalis, when the blood changes are serious.

The inflammations of this remedy are characterized by their intensity and by the tendency to the destruction of the tissues, which are inflamed. In these local inflammations of arsenicum, you will find burning lancinating pains the characteristic sensation. This is described by the patient as though hot coals were burning the parts. It is often accompanied with throbbing. Now the burning when arsenicum is the remedy indicates destruction

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of tissues, hence it calls for the remedy in gangrene and sloughing of the lung tissues; and it does not call for arsenicum when the burning is a mere sensation. Patients occasionally complain of burning pain, here and there, which arises from nervous causes only. Arsenicum does no good then. All cases in which arsenicum is called for are relieved by hot applications, and greatly aggravated by cold. Now the action of arsenic on the mucous membranes. We find it an excellent remedy in winter colds. The nose discharges a thin watery fluid, which excoriates the upper lip, and yet the nasal passages feel stuffed up all the time. As the cold creeps downward you find the case complicated with catarrhal asthma. Dyspnœa appears. In this respect similar to sanguinary burning, dryness in the eyes followed by copious lachrymation. Fluid coryza with frequent sneezing. Dry hacking cough caused by tickling in the throat, with dryness of the throat, crawling sensation, extending down behind the sternum. Under this heading we find eupatorium perf. a useful remedy. Cough with soreness and heat in the bronchi, flushed face, tearful eyes, coryza with sneezing, aching in every bone.

Under arsenicum we find the mucous membrane of the mouth, nose and throat is unnaturally red and dry. The sufferer complains of almost constant thirst. The pains which the arsenicum patient experiences, whether of the respiratory organs or otherwise, make him desperate and angry, almost furious in fact. In the frenzy it is somewhat similar to chamomilla, irritable, impatient mood. Pain intolerable, cannot be endured, but lacking the characteristic thirst and restlessness and burning pain of arsenicum. The arsenicum patient cannot lie down, particularly after midnight. He is greatly relieved by coughing with expectoration of tenacious mucus.

Antimonium tart., suffocated and oppressed, cannot get air, has to sit up in bed. Shortness of breath, suppressed expectoration, relieved by expectorating. You will at once recognize the similarity between the symptoms of this drug and those of hay fever.

Arsenicum has difficult breathing with great anguish, want of

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breath, must spring out of bed at midnight. Oppression of breathing on walking fast or ascending a height.

The mental condition is peculiar and guiding in all cases of the dreaded and loathsome disease affecting the respiratory organs. Fear of being alone at death. Dread of dying when alone on going to bed. Irritable, sensitive, feverish, and easily vexed. Fainting from weakness, from cough, from talking, from walking. Great prostration, cannot sleep from the want of breath.

Returning to the cough symptoms and the condition of the mucous membrane referred to, we find when the irritation extends down still further into the bronchi, then—

Phosphorus becomes the remedy. You find *phosphorus* indicated in bronchitis, especially in tall, slender persons of rather tubercular habit or tendency, inclined to stoop and to be hollow-chested. The cough is particularly worse on going from the warm room into the cold air, or in changes from warm to cold. It has dry, tickling cough, caused by irritation in the larynx and beneath the sternum. It is also indicated in cough made worse by the entrance of a stranger into the room, this being purely a reflex, nervous symptom. It is called for in cough provoked by strong odors. In fact perfumes or anything that will disturb the balance of the nervous system will bring on cough under *phosphorus*.

Phosphorus is particularly indicated in youth, both young men and women, who have grown too rapidly, who have delicate skin, long silky eyelashes, and who are of easy, graceful manner. The patient catches cold easily.

Under arsenic the patients have an old, shrivelled-up look, skin wrinkled, dry, cold and blue, or having cold, sticky perspiration. Bran-like scaly eruption with itching and burning, the burning increased by scratching.

Next I wish to mention the action of bryonia on serous membranes. Bryonia acts powerfully on these, producing inflammation. Hence we are called upon to prescribe it when the pleura is inflamed. The indications for bryonia in these cases of serous inflammation are particularly to be looked for after exudation has taken place. There are sharp stitching pains, worse from any motion. Comparing aconite with bryonia, you

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will find the same rule applicable in all affections of the respiratory organs or in all other troubles, calling for the remedies. Bryonia is indicated after and not before aconite. Take for purpose of illustration a typical case of pleurisy. In the beginning of the disease, when fever is high you select aconite, but just so soon as the fever commences to decrease, and as effusion begins, as indicated by the friction sounds, aconite ceases to be of any benefit, and bryonia comes in as an all-sufficient remedy. It is customary with some physicians to give aconite for the fever and bryonia for the pleuritic trouble. But this is useless. Bryonia is adapted to the whole case. It has not the same restlessness which demands aconite or arsenicum. The patient is quiet and is full of pain. He lies on the affected side. Why? Because by the pressure thus exerted on the ribs, he moves the affected parts less than he would, were he lying on the sound side.

Rumex has a tearing, persistent cough, aggravated by cool air, or by anything which increases the volume or rapidity of the inspired air. Arsenicum causes much burning tickling in the fossa; but since it so often concurs with apis it should be compared with the latter, especially when cough accompanies dropsy, heart disease, etc. Arsenicum, then, is really a concomitant. Belladonna may be misapplied for apis, but we ought to be able to distinguish the former by its greater constriction of the throat, and deeper inflammatory redness.

Ignatia induces a nervous cough, and the more the patient coughs, the more annoying is the irritation.

Carbo veg. agrees in hoarseness, rawness and tickling cough, but the irritation is as from vapor of sulphur.

Arsenicum patient complains of an acute, sharp, stitching, fixed or darting pain in apex, and through upper third of right lung (sharp, stitching pains through right lung, middle and lower third, bryonia and kali carb.). Burning and heat in chest, sometimes extending below diaphragm to stomach.

Chilliness in the chest in the evenings. Constriction of the chest when walking fast, when going up hill, with great anxiety and restlessness evenings; with oppressive anxiety at pit of stomach, burning or feeling as if excoriated and raw.

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Wheezing in chest with bruised pain between shoulders. Yellow spots on the external chest, upper part of chest yellow (sepia). Great weakness in the chest in attempting to move or sit up.

Bellows murmur, either from thinness of the blood or thickening of the aortic valves, especially if accompanied by wheezing respirations or frothy expectorations, forms an additional symptom for arsenicum in the early stages of tuberculosis.

Expectorations—frothy saliva, frothy sputa, yellow mucus, enveloped in or mingled with froth mucus streaked or specked with blood. Tenacious mucus, difficult to dislodge, with rattling in chest (kali bich.).

A frothy expectoration is the characteristic of arsenicum, and in the frequency with which it will be called for when the symptom is present it outranks all other remedies, although aconite, fer., lachesis, phos. and sil. and many others have it more or less prominently marked.

J. H. THOMPSON, M.D.

NERVES.

(1) *Starting when falling asleep.* Compare with

Bell. Which has "great restlessness, startings. Starts in affright, during and from sleep; during sleep, singing and talking loud; moaning."

Apis. Screams during sleep; also sudden starting; restless sleep and incessant dreaming; great inclination to sleep, but cannot from nervous restlessness.

Calc. carb. Aroused, as often as he falls asleep, by the same disagreeable idea; cannot sleep after 3 A.M.

Cham. Scarcely sleeps; and on falling asleep is tormented by anxious frightful dreams; during sleep starting up, crying out, tossing about, and talking; moaning, weeping and wailing.

Cimi. Starts during sleep. Children wake suddenly at night, terrified and trembling, covered with cool, clammy sweat. The so-called night-terrors for which *kali brom.* is indicated by the "child awaking screaming, unconscious, recognizes no one."

Ignatia. Single jerks of the limbs when falling asleep; the child awakes from sleep with piercing cries, and trembles all over.

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Cuprum met. Twitchings, jerkings, or startings during sleep.

Silicea. During sleep starts, jerking of the limbs, snoring.

Sulph. Frequent spasmodic jerking in the whole body; child jumps, starts, and screams fearfully; jerks and twitches during sleep; awakes with a start or scream.

Zinc. Twitchings in various muscles; the whole body jerks during sleep; during sleep cries out; awakes with fear; limbs and body jerk.

(2) *Hysterical spasms followed by exhaustion; frequent fainting.*

Hepar sulph. Has "fainting from slight pain;" also,

Ranunculus sceleratus. Has fainting with the pains (verat. a.).

Phos. Frequent fainting; pale, cold, sudden syncope; lying as if lifeless; fainting after stool, in diarrhœa; this symptom (fainting after stool) is also found under aloes, croton tig., and terebinthina; *sars.*, with difficult stool.

Nux vom. Tendency to faint from odors; in the morning, or after eating.

Nux mos. Disposition to faint; also fainting from pain, even when slight.

Opium. Faints every fifteen minutes; shuts eyes, hangs head; unconscious, jerks, sighing.

Phos. acid. Fainting after a meal; from loss of fluids; from emotions. Coffea also fainting from sudden emotions.

Pulsat. Fainting fits, great paleness of the face; shivering, coldness.

Sepia. Fainting after getting wet; from riding in a carriage; while kneeling in church.

Lachesis. Fainting, with pain in the heart; nausea; pale face, vertigo.

Laurocerasus. Long-lasting faints; rapid sinking of the forces.

Theridion. Faints after every exertion.

Ignatia. Hysterical fainting from worry, grief or affliction.

Moschus. The most efficient remedy for simple fainting in nervous subjects. Young girls or women who frequently faint.

(3) *Epileptic convulsions. Convulsions, with opisthotonos; foaming at the mouth.*

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Child lies as if dead; pale, but warm; breathless for some time. Epileptic convulsions. Tetanic spasms.

With *acon.* we have convulsions of children teething; heat, startings, twitching of single muscles; child gnaws its fist, frets, cries; costive, or dark, watery stools.

Æthusa. Epileptiform spasms, with clenched thumbs, red face, eyes turned downwards, dilated, staring immovable pupils, foam at mouth, teeth set; pulse, small, hard, accelerated.

Agaricus. Spasmodic motions; from simple involuntary motions and jerks of single muscles to a dancing of the whole body; twitching of eyelids and eyeballs; soreness of spine; worse at the approach of a thunder-storm.

Belladonna. Throws body forwards and backwards while lying, like constant change from opisthotonos to emprosthotonos. Clenches the teeth together with such force that they cannot be opened. Muscles of the face, jaws, and limbs, agitated by convulsive twitchings. Spasms of one and paralysis of the other side (also stram. and hell.). Stiffness of the whole body.

Cantharis. Convulsions, with dysuria and hydrophobic symptoms; bright light, a drink, or sound of falling water, touching the larynx or painful parts, causes or renews the spasm.

Chamomilla. Convulsions of children; legs moved up and down; grasping and reaching with hands; mouth drawn from side to side; eyes staring.

Cicuta. Convulsions, with loss of consciousness; frightful distortion of the limbs and whole body. Convulsions with opisthotonos; suddenly becomes stiff and immovable. (Ars., child lies as if dead, breathless for some time.) Tonic spasms renewed from the slightest touch, opening the door, or from loud talking. (Canth., by touching larynx, or by bright light; stram., spasm renewed by bright dazzling object, water, touch, or being spoken to; nux, spasm renewed by being touched.) Sudden rigidity, with jerks, afterwards great relaxation and weakness.

Cina. Convulsions of the extensor muscles; the child becomes suddenly stiff; there is a clucking noise, as though water were poured out of a bottle, from the throat down to the abdomen.

Cuprum. Has convulsions, with froth at the mouth, and opisthotonos, similar to arsen., but with cuprum the limbs are ab-

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ducted. Cuprum also has spasms while sleeping; here, similar to œnanthe crocata and silicea. Spasms each new moon (also silicea and causticum; calc. carb. has spasms at the full of the moon). Clonic spasms accompanying brain affections; spasms beginning in fingers and toes; spasms of children during dentition. The child lies on its belly and spasmodically thrusts the breech up.

Glonoinum. Convulsions; cerebral congestion; scanty or suppressed menses. Spasms, with the hands clutched, thumbs in palms; face red, eyes rolled upwards, then sopor. Left-sided spasms, with fingers spread. (Compare secale.) Face alternately red and pale. For uræmic convulsions this, probably, is our most reliable remedy.

Graphites. Cataleptic condition, conscious but without power to move or speak; and helleborus has epilepsy, with consciousness followed by deep sleep; and kali carb. has spasms, with full consciousness. Helleborus has convulsions in sucklings, with *extreme coldness*, while the children calling for acon., bell., cham., etc., are hot.

Automatic motion of one arm or leg in hydrocephalus.

Hyos. Convulsions of children, especially from fright (ignat., opium). Angular motions; jerks of single muscles, or sets of muscles; convulsive jerks (cicuta). Convulsions after meals; child sickens after eating, vomits or shows distress at stomach, sudden shriek, and then the spasm. Suffocative spells and convulsions during labor. (Gels., puerperal spasms, preceded by great lassitude; dull feeling in forehead and vertex, fulness in region of medulla, head feels big; heavy, with half-stupefied look; face deep-red; speech thick; pulse slow and full.)

Hypericum. Convulsions from every slight hurt or concussion. Prevents lockjaw from wounds in soles of feet, fingers, or palms of hands.

Ignatia. Convulsive twitchings, especially after fright or grief. Spasms of children, preceded by hasty drinking. Convulsions during dentition, with frothing at the mouth (ars., cup.); kicking with legs (cham.); during the commencement of exanthematic fevers (cuprum, repercussion of eruption, with convulsions, vomiting or gagging, pale face, and twitching of limbs). Convul-

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sions of children after punishment. Convulsions return at same hour every day.

Ipecac. Tetanic spasms from swallowing tobacco. Convulsions in whooping-cough; from suppressed exanthema from indigestible food.

Lachesis. Crawls on the floor, spits often, hides, laughs or is angry; spasms, epilepsy from jealousy, onanism, loss of fluids, comes on during sleep (cuprum, œnanth., silic.). Lachesis has cured lockjaw.

Lycop. Spasms, with screaming, foaming at the mouth, unconsciousness; throwing the arms about; cardiac anguish, imagines he will die.

Magnesia carb. Epileptic attacks; while standing or walking he frequently falls down suddenly with consciousness.

Magnesia mur. Hysterical and spasmodic complaints; she has many spasms, day and night, with great sleeplessness.

Nux vomica. Convulsions from emotions, as anger; from indigestion; preceded by constipation, jaundice, etc.; begins with an aura from the epigastrium. Opisthotonos, with consciousness; tetanic rigidity of nearly all the muscles of the body, with interruptions of a few minutes during which the muscles relax. Spasms, renewed by the slightest touch (cicuta, stram.). Deep sleep follows the convulsion (opi., œnanth.).

Œnanthe crocata. Epileptiform convulsions, followed by coma or deep sleep; convulsions, with vertigo, madness, nausea, vomiting, unconsciousness, risus sardonicus, eyeballs turned up, pupils dilated, swollen livid face, bloody froth from mouth and nostrils, convulsive respirations; insensibility, feeble pulse, prostration.

Opium. Spasms from emotions, fright, anger, etc.; children that have spasms from the approach of a stranger. Throwing the limbs or stretching the arms at right angles to the body, or, tetanic rigidity. Opisthotonos, with rolling laterally; spasms, begin with loud screams, then foam at the mouth; trembling of limbs; suffocation; eyes half-opened and up-turned; pupils large and insensible to light. After the attack, deep sleep, face remains deep-red and hot; stupor between spasms. Or, another condition calling for opium is this: Twitching, trembling of the

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head, arms, hands; now and then, jerks of the flexors; body cold, stupor; motion of the body and uncovering the head relieves.

Platina. Spasmodic affections of hysterical women, and of children; tetanic-like spasms, with wild shrieks, alternating with catalepsy; spasms, alternating with dyspnœa unto suffocation; twitching of single muscles; trembling, shivering, worse at dawn; spasms from sexual erethism (tarentula). Tonic spasms without loss of consciousness; face pale, sunken; child, after the spell, lies on its back, kicks off the clothes, and draws up the knees and spreads them apart.

Pulsatilla. From suppressed menses; epileptic convulsions; violent tossing of the limbs followed by relaxation; disposition to vomit; eructations; hysteria, the symptoms ever changing.

Sabadilla. Twitchings, convulsions, tremblings, or catalepsy from worms.

Silicea. Spasms spread from the solar plexus to the brain; come at night, or during new moon; attacks preceded by coldness of the left side; shaking and twisting of the left arm. Convulsions after vaccination.

Stram. Convulsions from the sight of dazzling objects; from touch (nux), or from being spoken to (cicuta). Opisthotonic convulsions, especially from fright (hyos., ignat.). Constant, restless movements of the limbs and whole body. Frequent twitchings (agaric.). Sudden jerks through the body (cicuta). Catalepsy (graph.). Paralysis of one, convulsions of the other side (bell., hell.). Dull.

Veratrum alb. Convulsions caused by religious excitement; also of children; anxiety, pale face; cold sweat on forehead; cough before or after the spasm. Tonic spasms, with contractions of soles of feet and palms of hands. Eclampsia parturientium; pallor, collapse, anæmia, or violent, cerebral congestion, with bluish, bloated face, wild shrieks, tearing the clothes. Puerperal mania, wants to kiss every one.

Veratrum vir. Violent spasms, like galvanic shocks; trembling, as if the child were frightened, and on the verge of a spasm. Opisthotonic convulsions in anæmic subjects from exhausting diarrhœa.

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Zinc. Spasms; child cross before the attack; body hot, restless at night, fidgety feet, right side twitches. Pale children during dentition.

In tetanic spasms, we may compare arsenic with belladonna, which has "tetanus, while working in the hot sun, unconsciousness, jaws fixed, head hot, feet cold;" with cicuta and œnanthe crocata. Under gels., we find the symptom "tetanic spasms, jaws locked." Hypericum prevents lockjaw from wounds in the soles, fingers or palms. *Secale* has tetanic spasms, with full consciousness, followed by great exhaustion. Spasms, with the fingers spread out.

In a curious work, entitled the *Medical Genius*, by Dr. Stacy Jones, the statement is made that, "in ordinary doses (10 to 30 drops), repeated every quarter to one-half hour, passiflora incarnata completely controls convulsions, spasms, lockjaw. It never fails to cure lockjaw in a horse." If this statement be true, we have no use for other remedies, but I give it here for what it may be worth; for myself, I place but very little value upon it. The same *Medical Genius* says, he has never failed to cure puerperal eclampsia with stramoniumθ, in about ten-drop doses, frequently repeated. This you have also for what it is worth. I have seen but two cases of puerperal convulsions; one of them recovered without stramoniumθ; the other, and more recent one, died while taking stramoniumθ.

W. J. MARTIN, M.D.

SLEEP.

Restless, uneasy sleep, with moaning. *Bell.* has sleep, with moaning and tossing about. *Lachesis* has tossing about, moaning during sleep. *Podo.* has restless; drowsy; moaning; whining; half-closed eyes (especially in children). *Kreos.*, like podo., has child sleeps with half-open eyes, and, while bell. and lach. are similar to arsen. in restless sleep and moaning, they are distinguished by this, that arsenicum has more rest and sleep before midnight; it is after midnight that the arsenicum patient cannot sleep or rest, and does his moaning; but with bell. the patient tosses and rolls, and moans until after midnight, then has better rest the remainder of the night. Lach. is, also, especially more sleepless and restless before midnight, but the sleep

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of lach. is not followed by benefit, but by an aggravation of the patient's condition. Kreosote, too, is usually better after sleep.

Arsenicum has dreams full of care, sorrow and fear; dreams of thunder-storms, fire, black water, darkness, dead people and corpses.

Rhus dreams of great exertion, as swimming, roaming, etc., dreams from which he awakes, feeling very tired. *Amm. mur.* dreams of falling into water. *Bell.* dreams about murders, street-robbers, of danger from fires. *Silicea* has anxious dreams of murders, horrid things, and also lascivious and pleasant dreams. *Pulsat.* has confused, frightful, anxious dreams; sleeps late in the morning, sleepless the first part of the night. *Psorinum* has vivid dreams continuing after waking, dreams of robbers, danger, travelling, etc. *Bryonia* dreams about household affairs; about the business of the day, of disputes and vexation.

Ignatia has the symptom dreams of one and the same object the whole night through; while *nux vom.* has dreams full of bustle and hurry; the night seems long. *Nat. mur.* dreams that robbers are in the house, and will not believe the contrary, until search is made.

Kreos. dreams about being out in a snow-storm (ars., a thunder-storm); of falling from a height; of being poisoned; of bright fire; of very dirty clothes-wash (ars., of black water).

Lycop. has anxious dreams; child awakes terrified, as if dreaming, and is very cross; kicks and scolds.

Petroleum dreams of somebody lying alongside of him in bed.

In the September (1888) number of the *Homœopathic Physician*, it is given as a peculiar symptom of arsenicum by Dr. Schmitt, of Rochester, N. Y., and one that he had verified frequently, that "*the patient wants to sleep with his hands up over his head.*"

W. J. MARTIN, M.D.

NECK, BACK AND LIMBS.

In these parts arsenic produces no especially characteristic symptoms, and would be indicated in affections of them, when its general characteristic symptoms are present.

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Neck and Back.—Nape stiff, as if bruised or sprained. Bruised pain in small of back. Loss of strength in small of back.

Rhus tox. has pain in small of back, as if bruised, relieved by lying on something hard, or by motion.

Bell. has painful stiffness between the shoulders, and in the nape of the neck.

Sepia has stiffness of the nape of the neck. Pain in small of back, particularly with stiffness, improved by walking. Belching relieves the pain in the back. Also, great weakness of the small of the back, generally from disease of the uterus.

Upper Limbs.—Carroll Dunham says that in the upper extremities the symptoms are few, chiefly those of loss of power.

Cowperthwaite gives drawing, jerking, and tearing from tips of fingers unto the shoulders. Hands and lower half of forearm dark and livid.

Lower Limbs.—In the lower extremities, Carroll Dunham says that the symptoms are numerous, but may be reduced to three varieties: pain, spasm, paralysis. The pains are stitching, boring, and tearing. The spasms are generally tonic contractions. The paralysis occurs, generally, in fatal cases, not long before death, and is hardly a specific effect of arsenic, but a forerunner of dissolution.

Cowperthwaite gives the following symptoms: Sensation as if limbs would break down on going up-stairs. Uneasiness in lower limbs; cannot be still at night; has to change position of feet constantly, or walk about to get relief (rhus tox.) Coldness in lower limbs. Tearing, sticking, periosteal pains along the limb to the big toe. Violent, drawing, tearing pain in the right foot. Drawing pain in legs when resting feet upon the floor, while sitting. Cramps in the calves. Sulphur has heaviness of limbs when walking, and cramps in the calves at night; also, with diarrhœa, and in the soles at every step.

Arsenic has œdematous swelling of the feet. Excessive weakness and exhaustion of limbs, obliging him to lie down. Twitching, tremor, trembling, weariness of the limbs.

In speaking of the paralysis which arsenic produces, Hughes says, that "the arms are involved nearly as often as the legs. Cramps and contractions in the paralyzed limbs are common;

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but the most invariable concomitant is neuralgia. This generally coexists with loss of sensibility, at least to everything but cold, by which also the neuralgic pains are brought on, and aggravated. The paralysis is most complete in the hands and feet, and spreads, if it do so, periphero-contra. There is a sense of great restlessness in the limbs, when the pains are present. The seat of mischief seems to be the spinal cord. In a case observed by Huss, the spine was found tender on pressure; and Wibmer says, that in autopsies, the cord is always seen to be affected, especially with congestion of the lumbar portion and cauda equina. Velpeau now announces that he has succeeded in developing an acute myelitis with it in a dog, and three undoubted cases of this inflammation in the human subject have been traced to its influence. Arsenic may thus occasionally find place in the treatment of myelitis, and of epilepsy; but we have, as yet, little experience of it in these diseases.

R. K. FLEMING, M.D.

SKIN SYMPTOMS.

Ars. a. produces hardening and induration of the skin. This is characteristic, which renders it of prime value in eczema and other cutaneous indurated conditions.

It is the great sheet-anchor with allopaths in this disease, Donovan's solution being one of their favorite methods in administering it. In nearly every instance in which arsenic is thus used, it produces a chronic poisoning, which closely resembles the eruption of graphites, and *graph.* is the best remedy to employ to correct its abuse. This chronic eruption of arsenic poisoning is intensely itchy, and is always aggravated by cold and scratching, and better in warm weather. The patient informs you that he has a "winter disease," and dreads the winter season, as the trouble is then sure to come back.

Ars. eruption appears first as vesicles which, subsequently, form pustules, and finally scabs, ameliorated by heat in general, and aggravated by cold.

There are upwards of fifty drugs that have vesicular eruption more or less prominently indicated in their pathogeneses. Of

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these, however, only nine or ten have vesicular eruptions, similar to ars., and for which a mistake might be made in selecting a remedy. They are *rhus t.*, *sepia*, *lach.*, *clematis*, *graphites*, *sulph.*, *bry.*, *phos.* and *merc.*

When about to differentiate between *ars.* and any other drug, the prominent and leading *characteristics* of the former (ars.) must ever be borne in mind. These are *debility*, *œdema*, *emaciation*, *intermittence*, *burning*, and *inflammation* of membranes and skin. If, to one or more of these, we add its *peculiar thirst*, drinks little, but often; its restlessness owing to anguish and anxiety; its ameliorations from warmth, and warm things, and from motion; and its time of aggravation—after midnight—from 1 to 3 P.M., we will have a picture of *ars.* that will enable us to make our prescriptions with almost mathematical accuracy, whether it be for skin disease or for any other trouble.

Rhus tox. has vesicles on a red, erysipelatous surface, that invade large areas rather than penetrate deeply. Itching is lessened by scratching. It is forgetful, and dull of comprehension, while *ars.* has a clear mind to the last moment of life.

Rhus has a *sore*, dry, cracked tongue, with red, triangular tip, that feels scalded. *Lyc.*, *psorin.*, *sang.* and *secale* have a scalded feeling of tip of tongue.

Ars. a. has also a triangular, red tip on tongue, but it has, in addition, a *red* streak down the middle, with dryness and burning in mouth, pharynx and œsophagus; sometimes raised papillæ on tip of tongue.

Cyclam. has red tip of tongue, with burning blisters.

Sepia has vesicular eruption, attended with much itching; aggravated by scratching, followed by desquamation; worse about the joints; circular eruption; ringworms.

Ars. a. has a dry, scaly desquamation that may appear on any part of the body in irregular shapes; not circular. The indolent mood and mental indifference of *sep.* will readily distinguish it from the clear, active, fearful restless mind of ars.

Lachesis has yellow or purplish blisters; deep-seated, bluish blisters which appear after scratching. All the concomitant symptoms are worse after sleep, in the open air, and from *sunlight.*

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Clematis has burning vesicles, which pustulate and discharge a yellowish, corrosive ichor. Urine is discharged in drops, or intermittingly. It resembles *ars.* in many respects, but it has more rawness, aggravation from washing in cold water, from wet poultices and from warmth of bed. Its moist, eczematous eruption alternates with dry scabs.

Graphites bears a close analogy to *ars.* Both have a moist eczema, and a vesicular, burning, itchy eruption. *Graph.*, however, differs widely from *ars.* in the nature of its glutinous discharge, which is characteristic. The skin is dry, and much inclined to crack, notwithstanding the humid nature of its eruption. Calc. c., dulc., merc., hep. and oleander have moist eruptions closely resembling *graph.*, but the sticky, viscid, honey-like discharge of the latter notably marks its individuality from all others. Its moist, scabby eruption—most frequently behind the ears, and often over the entire scalp—forming *massive, dirty crusts,* which mat the hair together and are sore and painful to touch, is readily recognized from the bran-like, scaly eruption of *ars.*, with its hardened parchment-like skin; the eruption being most generally on the face, legs and genitals, while the eruption of *graph.* is worse on the chin, behind the ears, on the palms of the hands, and on the left side. The *graphites* skin never perspires except in fever.

The *ars.* skin has a cold, clammy, sour, offensive sweat, lessened by motion, and often disappears on falling asleep.

Emaciation is one of the marked features of *ars.*, while *obesity* is a characteristic of *graphites.*

Sulphur has humid, offensive eruption on the head, with thick pus, yellow crusts, itching, bleeding and burning, thus far resembling *ars.*, *graph.*, *hep.*, *merc.* and *sil.* It has voluptuous itching, with soreness after scratching—the itching is lessened by scratching—the eruption is general, with the exception of the *face.*

Apis has no eruption on the *feet*, but is general elsewhere. The sulphur patient sweats much on the *back*, and on the parts that itch.

Carbol. ac. has an exceedingly itchy eruption, better after rubbing, but leaving a *burning* pain. It may be further distinguished

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by its stertorous breathing, like opium, and by its profound prostration and languor.

Merc. has voluptuous itching, ameliorated by rubbing, but aggravated by scratching; sweats freely, especially the *front* part of body; the sweat is general except the *feet.* The sweat smells sour and mouldy, and is not followed by relief (ant. t.).

Ars. is aggravated by the slightest touch, and is *painful* and *burning* after scratching. It has a warm sweat, which, if in sufficient quantity, always ameliorates. This warm sweat soon becomes *cold* and *clammy.*

NOTE.—*Verat. a.* has a cold sweat that comes out (cold) through the body, especially the *forehead.*

Camphor is noted for its icy, dry coldness and absence of sweat.

Plumbum has entire absence of sweat, skin dry, yellowish or bluish.

Ars. a. has flat superficial ulcers on the leg, covered with *gray crusts* and surrounded by an inflamed, high border, often proud flesh. They are *burning* and painful to touch, and copiously discharge, either black, coagulated blood, or else fœtid pus. Warm applications are grateful and beneficial. *Burning* and pain of ulcers are worse after midnight, when sleeplessness predominates.

Bell. has ulcers with slight discharge of pus. Pains are worse before midnight, when sleeplessness most prevails.

Carbo veg. has deep ulcers with scanty discharge. It has a marked aversion to milk. Costiveness usually predominates.

Ars. has an appetite for milk, and a diarrhœa predominates, which is usually (not always) painless.

Both *ars. a.* and *carbo veg.* cure ailments from drinking ice-water.

Ars. troubles are better after sufficient sleep. *Carbo veg.* ailments, like those of *lach.*, *opium*, *stram.*, *hep. s.* and *sulph.* are worse after sleeping.

Hep. s. has generally deep ulcers, with scanty discharge that smells like rotten eggs. They are very sensitive to contact, as if pricked by a *splinter* (nit. a., arg. n.). Little pimples surround the principal ulceration (sulph.).

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Lach. has carbuncles on a purple base, surrounded by small boils. It has a scanty discharge from ulcers. Old scars break open and bleed. Ulcers on the tibia; worse both from touch and pressure, and in spring and summer. Eruptions and ulcers are painful. Proud flesh often accompanies the ulcers.

Ars. a. Old scars *burn.* Ulcers predominate on the gastrocnemius. These ulcers are worse from slight touch, but better from pressure, and are always worse in the fall and winter, and in dry, cold weather.

Rhus tox. has deep ulcers, usually accompanied by itching over the whole body, ameliorated by scratching, by continued motion, by heat, and in dry, warm weather. These ulcers are painless and have a copious discharge. "A constant discharge of water on dropsical legs."—Hering.

Mur. ac. has painful, deep, putrid ulcers on legs, with *burning* at circumference of sores, the ulcers are covered with *scurf.* Itching relieved by scratching. The *left leg* and the *upper right side* are the parts most frequently involved. *Ars.* has affections on the *right leg* and upper *left side;* eruption on bend of right knee.

Lycopodium has fistulous ulcers with hard, red, shining, everted edges and inflammatory swelling of the affected parts. Ulcers of the leg refuse to heal, with tearing and itching at night; burning when touched. They are made worse by dressing or poulticing. The discharge, which is copious, is often golden-yellow. "If on dropsical legs, there is a constant and spontaneous" discharge of "the waters" (rhus t.).—Hering.

Nitr. ac. has ulcers, with *irregular edges;* deep rhagades that bleed on touching; edges hard and everted; exuberant granulations; stinging pains as of a *splinter* (arg. n., hep.). The concomitant mouth and throat symptoms are characteristic—cracks of the commissures of the lips; corners of mouth ulcerated; blisters and ulcers on the tongue (borax, nux v., sepia, thuja). Profuse flow of saliva (iod., ign., kali hyd., merc.). Pricking as from a splinter in the throat (alum, arg. n., hep.). Ulcers discharge a watery pus. Itching is relieved while scratching; aggravation while sweating (sepia), from touch, active motion, on walking out-doors in wet weather, and ameliorated by passive

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motion, riding in a carriage, in dry weather, after sweating, and from rubbing and scratching.

Kali iod. has deep-eating ulcers, with curdy pus, characteristic of chancres; usually accompanied by violent headaches, causing hard lumps on the head, œdematous infiltration of tissues (apis m., apoc. c., ars. a., dig., lach.).

Silicea has suppurating ulcers. Itching is not lessened by scratching, but is either aggravated or unchanged; aggravated by touch, from pressure, from rubbing and scratching, in dry weather, in the open air, and from cold. These ulcers are formed from painful pustular eruptions, and are characterized by *stinging*, *sticking*, *burning* pains; offensive with ichor; proud flesh (*ars.*, carbo veg., graph.). The discharge is usually scanty. The silicea patient is worse in spring (sulph.).

Sulph. has painless ulcers, with raised, swollen edges, bleeding easily, surrounded with pimples, like hep., and discharge a fœtid pus. Aggravated by washing or moistening, from warmth (except the *heat of the stove* which ameliorates), worse during rest, after sweating, from drinking wine, and *after drinking* generally. Better from cold, from motion, in open air; when resting on sore limb, or when letting it hang down, or when resting it *on* something, from pressure, from rubbing, and scratching. Numbness of feeling and absence of pain are marked features of sulph. ulcers.

The *ars.* patient is hopeless, avaricious, malicious, loquacious, has a trembling voice, and is more frequently imbecile than insane. Ailments from grief, sorrow, vexation, with reserved displeasure. He is tired of life, but afraid to die; desires milk, coffee, beer, sour things, and especially brandy. Has aversion to sweets. Is *worse* from cold and cold diet, after sweating, from uncovering the head, from bodily exertion, in dry weather, after breakfast, and after midnight. Is *better* in wet weather, from warm diet, wrapping up the head, on an empty stomach, from washing and moistening the parts, from warmth of the bed (*rest* in bed aggravates), and from warmth in general; after sufficient sleep (after disturbed sleep—when aroused from—ars. has an aggravation, so also has nux v., phos., puls., sep., china, and ipec.).

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Skin diseases predominate on the inner side of the thigh; calves of legs, tips of fingers, face and lips. *Ars. a.* has muscles and skin rigid; while calc. c., cham, china, ferr., lach., lycopod., op. and ipec. have skin and muscles lax. *Ars.* patient thinks he has cancer of the throat (Miller).

THERAPEUTIC RANGE *of ars a. in diseases of the skin.*—Acne, alopecia, anthrax, ecthyma, eczema, epithelioma, erysipelas, fibroma, herpes, leprosy, leucoderma, lichen planus, lichen simplex, lupus vulgaris, pernio, chronic pemphigus, pityriasis, prurigo, purpura, psoriasis, rosacea, urticaria, seborrhœa, squamous syphilides, tinea favosa, tinea versicolor, zoster, miliaria, ichthyosis.

AGGRAVATIONS AND AMELIORATIONS.

Arsenicum album. At night, especially after midnight, between the hours of 1 *and* 3 A.M., from cold in general, cold air, cold food (ice-cream), cold drinks, cold washing, after eating or drinking, from lying with the head low, from anger with anxiety, before falling asleep, on awakening, on entering a cold place, from exertion of the body, on ascending, after moving (moving followed by exhaustion); from fruit, milk, wine; during perspiration; from running or walking fast; from a scald or burn. *Arsenicum album* always *wants to be wrapped up warm.*

Arsenicum album. General aggravation from cold, except headache, which is relieved by cold washing and cold air. Cold, damp cellar brings on complaint (sciatica); in this respect similar to dulcamara, which has diarrhœa from taking cold in damp cellars, or in low, damp places or damp weather.

Rhus tox. While at rest, and between the hours of 11.30 P.M. and 3 A.M., before a storm, on beginning to move; from getting wet, especially while overheated.

Belladonna. After 3 P.M. on moving; from touch, from draft of air, in hot weather, from heat of the sun, takes cold from uncovering the head, takes cold after cutting the hair; from the least jar of the bed or chair (which aggravates the patient).

Bryonia alb. From motion, from heat, from warm food; after eating, while coughing; in the morning; in hot weather;

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whenever the weather becomes warmer; diarrhœa aggravated by every hot spell of weather; after suppression of cutaneous eruption; all ailments worse from the change of cold to warm weather.

Chamomilla. From cold in general, in cold air, in cold and dry weather, from coffee.

Ledum palustre. From heat, especially heat of bed;. from motion; at night; from wine.

Natrum muriaticum. While lying down, especially in morning or evening at 10 A.M.; after exertion; in heat of sun; heat in general.

Pulsatilla. All symptoms are provoked by being shut up in a close, warm room. Faint and weak in the morning, must go to the door for air. Fresh air always relieves. *No* thirst.—*Sulphur.* Attacks of suffocation, especially at night in bed; want doors and windows open.—*Pulsatilla.* Chilly, even in a warm room; chilly with the pains. Faint and bad feeling in head in a warm room. Despite the chilliness resulting from anæmia the open air acts as a stimulant on the sluggish flow of blood. As we know, *pulsatilla* is useful in varicose veins of the limbs, or about the testicles (varicocele); also in epistaxis of a passive character, an important analogue, hamamelis, vies with it in these conditions. *Pulsatilla* has many analogues, actea, chamomilla, last but not least caulophyllum. Pains shift about, and so severe the patient can hardly bear them. She almost smothers if the room is closed.

Lycopodium. After 8 P.M., from continued motion.

Rhus tox. From cold; from warm food and drink.

Pulsatilla. In open air; in a cool place; when lying upon the back; by keeping eyes and body perfectly still; hot water feels grateful; no thirst, no appetite.

Graphites. From eructations; from walking in the open air.

Hepar sulphur. From warmth; from wrapping up warmly.

Silicea. Lack of vital warmth, even when taking exercise; head is wet from sweating, particularly at night; likes the head wrapped up.

Rhus tox. By continued motion; from moving affected parts; in warm, dry weather.

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Arsenicum album. Gangrene and all symptoms better from heat. Exhaustive neuralgia of the left eye, supraorbital, relieved by warm applications; wants head and shoulders wrapped up. Hasty in all motions, which give relief.

Argentum nitricum. Hasty only in walking, must walk fast; patient very impulsive.

ARSENICUM ALBUM.—AMELIORATIONS.—From warmth in general, warm or hot things, from hot applications or hot drinks; must sit near a warm stove with shoulders and head wrapped up.

Bryonia alba. Just the reverse; better in cool weather, in a cool room, from cold food, and while sitting, while lying, especially on the painful side.

Belladonna. On bending or turning the affected part; while reposing; while standing; while wrapped up well in a warm room.

Secale cornutum. In the cold air, and from getting cold; from sweat; from stretching out the limbs; *after vomiting.*

Arsenicum album. On going down stairs; lying with the head high; from rapid motion; found frequently indicated in teething children, where they are pale and weak and want to be carried rapidly.

Chamomilla. The child is excessively fretful, peevish, and irritable; must be carried up and down the room slowly; better from cold water; from warmth in general; the air being warm; in damp and wet weather.

PROVINGS OF ZINCUM PICRICUM.

BY CHARLES MOHR, M.D., PHILADELPHIA.

I.

LOUIS D. LIPPITT, Providence, R. I., æt. 20 years, single, medical student. Height, 5 ft. 10 in.; weight, 155 pounds; constitution, good; temperament, nervous; former diseases, pertussis, measles, varicella; normal pulse, lying 61, sitting 63, standing 72; normal respiration, 18; normal temperature, morning 97.7°, evening 98.6°; urine, 30 oz. per diem, yellow, sp. gr.

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1019, acid, occasionally depositing uric acid crystals after standing several hours; stool, one daily; sac. lac. test, negative.

Drug—*Zincum picricum*, 6x trituration, 1 grain doses.

Daily Record.

First day.—Took drug at 8 A.M., and at 2.15, 5.15 and 8.15 P.M. No effect.

Second day.—Took drug at 7 and 10 A.M., and at 1, 4, 7 and 10 P.M. No effect.

Third day.—Took drug at 7 and 10 A.M. No effect.

II.

Grant M. Kistler, Mantz, Penna., æt. 22 years, single, medical student. Height, 5 ft. 6 in.; weight, 130 lbs.; constitution, weakly; temperament, nervous; former diseases, measles and pneumonia; use of stimulants, occasionally drink beer or porter; normal pulse, lying 60, sitting 66, standing 71; normal respiration, 18; normal temperature, morning 98°, evening 98.6°; urine, 50 oz. per diem, pale yellow; stool, one per diem, costive; sac. lac. test, band-like pressure in forehead, and pain in cardiac region.

Drug—*Zincum picricum*, 6x trituration, 1 grain doses.

Daily Record.

First day.—Took a dose every four hours, and experienced the following symptoms: frontal headache with fulness of head; congestion of the eyes; cold sensation in the throat; drawing, tearing pain in the cardiac region; weakness in both extremities with marked prostration.

Second day.—Continued to take a dose every four hours, and note following effects: pressing pain in the forehead which is better from motion; giddiness; pain in the cardiac region of a sharp, cutting character, as if some instrument were driven into the apex, worse on sitting still, better on motion; tearing pain in the epigastric region.

Third day.—Took four more powders at intervals of four hours. Pressing pain in the forehead still continues, and is worse when sitting still; frontal headache; dilated pupils; tingling

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sensation in the tongue, extending down the throat; pain in the cardiac region, better on motion; pain in stomach, with nausea.

Fourth day.—Was restless during night. No further effects.

III.

Malvern J. Lyon, Atlantic City, N. J., æt. 29 years, married, medical student. Height, 5 ft. 9 in.; weight, 150 pounds; constitution, good; temperament, nervous; idiosyncrasies, very susceptible to colds from slightest draft of air on head, and producing occipital headache; former diseases, measles, shingles, mumps, diphtheria; normal pulse, lying 63, sitting 70, standing 76; normal respiration, 20; normal temperature, morning 98.6°, evening 97.8°; urine, about 4 pints daily, sp. gr. 1022, excess of phosphates; stool, one every 36 to 48 hours, normally voided; sac. lac. test, negative.

Drug—*Zincum picricum*, 6x trituration.

Daily Record.

First day.—Took 1 grain at 1, 5 and 9 P.M. At 11 P.M. have dulness and heaviness of head; dizziness when rising from sitting posture.

Second day.—Slept well all night, and feel well this morning. Took 1 grain at 6 and 10 A.M. At noon my head aches; pains are post-orbital; teeth ache. At 1 P.M. felt a sharp pain for an instant in centre of left lung. At 2 P.M. took 1 grain. Walked to beach and suffered much with a not uncommon form of headache for me; pain is aching in character, extending from base of orbits to occiput, worse when attempting to read or study, or when in the sun. From 4 to 6 P.M. had slight nausea. At 6 P.M. took 1 grain. Headache continued as already described with slight nausea until bedtime. Could eat no supper. Temperature at 11 P.M., 97.3°.

Third day.—Arose all right after a good night's sleep. Took 1 grain at 7 and 11 A.M., and at 3 P.M. went out for a walk, was caught in a shower, and ran hard to escape a wetting. After stopping felt a severe and sharp pain in left lung, with some pain in right lung. Took a drink of cold water, which created a very uncomfortable feeling in the stomach, and a sensation as

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if too much wind were in bowels. At 9 P.M. temperature was 97.5°.

Fourth day.—Retired at 1 A.M. after experiencing at irregular intervals since yesterday afternoon the sharp pain in the left lung. The pain was relieved by taking a full breath, and would begin again when the inspiration was not forced. Could not study with accustomed vim. Awoke at 7 A.M. without any symptoms.

IV.

Same prover, after an interval of eleven days, during which no symptoms were experienced.

Daily Record.

First day.—Took 5 grains at 9.30 P.M., at which hour temperature was 98.2°.

Second day.—Temperature 98.1°. Took 5 grains at 7 and 11 A.M. and 3 P.M. During a long walk felt a sharp stitching pain in region of right kidney, and soon after, at 5.30 P.M., a few sharp pains under left scapula. At 9 P.M., while out walking, had a sharp pain in the right ankle joint, come and go quickly.

Third day.—On awaking this morning, had a sharp pain in the inner canthus of the left eye, lasting nearly a minute, and soon after felt a dull pain in centre of left lung. Took 5 grains at 8 A.M., and went out riding. At 10 A.M., had a dull heavy pain in left lung, which continued for a long time, with short intermissions, and relieved by taking deep inspirations. (The lung pains are entirely new to me.) At 12 M., took 5 grains. At 3.30 P.M., felt a sharp piercing pain in the inner canthus of left eye again. At 4 P.M., took 5 grains; from 7 to 9 P.M., felt more or less dizzy, especially while engaged with my books and writing.

Fourth day.—Was awakened at 6.30 A.M., with a severe backache in region of kidneys, and found myself yet with the dull pain in the left lung. Took 5 grains at 7 A.M. From 10 to 11 A.M., had quite a severe frontal headache with now and then sharp pains in the right occipital region. Took 5 grains at 11 A.M. The headache still continues, and extends down the cervical region from the base of the brain; reading begins to affect the

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eyes. Took 5 grains at 3 P.M. Headache, which has assumed a neuralgic form, and which changes from region to region, now occipital and now frontal, lasted until 10 P.M., and became so annoying that I had to give up all work. Passed during early evening large quantities of clear, watery urine. Temperature at bedtime, 98°.

Fifth day.—Slept well all night, and am well this morning. At 11 A.M. took 5 grains. Had a severe colic at 2 P.M., for an hour, especially while eating dinner. After dinner had a very depressed feeling in both lungs, with, now and then, dull pains, relieved by filling the lungs with air. The pain in lungs lasted all the afternoon and evening.

Sixth day.—Those lung pains continue yet. Have had sharp pain several times to-day, just under the border of the left ribs in a line drawn from the nipple, especially when walking. Have had more or less dizziness to-day, but not enough to inconvenience me. Evening temperature, 98°.

Seventh day.—Was awakened at 6 A.M. with a dull, heavy pain in the epigastrium, as if I had eaten some indigestible food. Felt in a few minutes as if I would be driven to the water-closet, but managed to control the desire for a stool, although rumbling and perceptible peristalsis continued until 9 A M., at which hour I evacuated the bowels of a very mushy stool, without pain. I never had a diarrhœa in my life, but since taking the drug, I notice that, daily at 9 A.M., I have been *driven* to evacuate the bowels, and on some days have had a feeling as if I must go to stool more than once, but could resist the desire. The rumbling and uneasiness of the bowels has continued all day with, now and again, slight colicky pains. The dull pain in the lungs still continues.

Eighth day.—This morning the uneasiness of the bowels lingers with slight pain, but the amount of relieving flatus passed leads me to think that the trouble is about spent. No further effects.

V.

Charles H. Wells, Philadelphia, Pa., æt. 28 years, married, dentist. Height, 6 feet; weight, 148 pounds; constitution,

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good; temperament, sanguine; idiosyncrasies, none; former diseases, none; use of stimulants, none; use of narcotics, none; normal pulse, lying 57, sitting 64, standing 72; normal temperature, morning 98.2°, evening 98.4°; urine, from 9 A.M. to 7.30 P.M., passed 18 ounces, color light, reaction acid; stool, twice daily, normal; sac. lac. test, negative.

Drug—*Zincum picricum*, 6x trituration.

Daily Record.

First day.—Took 1 grain at 8 A.M. and another at 12 M. Soon after second dose, felt a slight uneasiness in the stomach, a mixture of nausea and pain; slight pains, difficult to describe and locate, in different parts of body, with pain of a decided neuralgic character in head, and vertigo. Urine decidedly increased in quantity, and a feeling as if I must void it all the time. This urinary symptom is associated with a nervous feeling and bad taste, and yet with a desire to take food or drink constantly. Eating does not long satisfy the increased desire for food. Legs feel weak and heavy. Feel sleepy and indolent.

Second day.—The urinary increase continues, but the other symptoms have subsided, except the head symptoms and the weakness of legs and indolence. Pulse, 80; temperature, 98.8°.

Third day.—Urine still increased in quantity; bladder has a cleared-out feeling. Feel irritable; vexed if things do not go smoothly. Headache over left side of the dome of the skull. Belching, with a disagreeable taste. Pulse, same as before proving, but less strong. Temperature, 98.5°.

Fourth day.—No symptoms up to 9.30 A.M., and took 1 grain. Soon felt an uneasiness in stomach and some nausea. Later, experienced little shooting pains through the abdomen and in region of stomach and liver. At 10.30 A.M. took another dose, followed soon by dull pain in head. In evening, all symptoms have subsided.

Fifth day.—Have no symptoms.

Sixth day.—Have a dull, sleepy feeling, and aching back of orbits which reading increases. No further effects.

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VI.

Same prover, after an interval of several days, during which no symptoms were experienced.

Daily Record.

First day.—At 8.30 A.M., pulse was 60, temperature 98°. Took 2 grains at 8.30 A.M., and 2 grains at 9 30 A.M. Soon felt a desire to eat, with a nervous uneasiness in stomach, and an easily exhausted feeling. Looking at anything closely causes aching in eyeballs.

Second day.—On rising this A.M., felt a sharp, tearing pain extending through the left chest from above downwards; pain was so severe as to take my breath. No other symptoms experienced to-day.

Third day.—At 1 P.M. took temperature, and found it 98°. Took 2 grains at this time, and at 2.30 P.M. felt very sleepy and depressed, associated with a nervous uneasiness as if I could not keep still; head feels very heavy.

Fourth day.—Just after awaking and turning over in bed, felt an intense tearing pain across upper abdomen, seemingly through liver and stomach. Have a nervous irritation about bladder, with a feeling as if micturition would be a comfort, but, on attempting to urinate, cannot. Feeling of hunger associated with the bladder symptoms, but food does not seem to satisfy the craving. The quantity of urine voided to-day, is about as usual.

Seventh day.—Since the fourth day have had a continuance of the desire to urinate from nervousness of the bladder, and now and then, slight shooting pains in various parts of the trunk, with soreness of the nerve-endings.

Eighth day.—No effects noticed.

VII.

Same prover, after an interval of five days.

Daily Record.

First day.—Took 3 grains at 7 A.M., when pulse was 60, temperature 97°. At 8 A.M., took 3 grains more, and soon experi-

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enced a dulness of the head, languor, and when looking intently, aching of the eyeballs.

Second day.—Took 3 grains at 8 A.M.

Fourteenth day.—Since taking the last dose, have frequently felt languid and depressed in spirits. The irritation at the bladder, with a desire to urinate, has been almost continuous, but, many times, only a few drops of urine are voided. Have also had slight, shooting pains in various parts of body, in head, behind sternum, in abdomen, and down the limbs. Have almost complete loss of sexual desire, and feel sure I would fail of an erection, if coitus were attempted. At this stage of the proving I have deemed it wise to stop. The bladder symptoms, which have been the most persistent, are entirely new to me; I learn, on inquiry, however, that, in childhood, I had a weak bladder, having been subject to wetting the bed at night.

THE REPORT OF THE BUREAU OF GYNÆCOLOGY.

THE report of the Bureau of Gynæcology, in the absence of the chairman, Dr. C. P. Seip, was presented by Dr. B. F. Betts. It included the following papers:

Erosions of the Os Uteri. By Millie J. Chapman, M.D.

Cervical Endometritis. By T. M. Bulick, M.D.

Vaginismus. By J. W. Thatcher, M.D.

The Influence of Gonorrhœal Infection in the Development of Pelvic Disease in Women. By B. F. Betts, M.D.

EROSIONS OF THE OS UTERI.

BY MILLIE J. CHAPMAN, M.D., PITTSBURGH, PA.

EROSIONS of the os uteri are found in three forms—the simple, papillary, and the follicular. A variety of opinion exists about the causes, and even the condition, but our most recent pathologists tell us "that the cervical canal is first inflamed. There are

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granular patches with irregular outline, which extend beyond the limits of the os externum. These have a red appearance, similar to the cervical mucous membrane, and, therefore, are sharply defined from the paler mucous membrane which covers the vaginal portion of the cervix. The apparently raw surface is covered with a single layer of epithelium. The cells are smaller than those which line the normal cervical canal; the thin layer cells allow the subjacent vascular tissue to shine through, hence the redness of color. The surface is further thrown into numerous folds, producing glandular recesses and processes; these processes cause the granular appearance. This constitutes the *simple erosion.* If the recesses are long and narrow the surface is split up into distinct papillæ; this constitutes the *papillary erosion.* If the ducts of the glandular recesses become obliterated the secretion will distend the gland below and produce retention cysts; these will increase in size, and may come to the surface and burst; this forms the *follicular erosion.* The raw-looking surface is, therefore, a newly formed glandular secreting surface, resembling in structure the cervical mucous membrane." This addition to the extent of secreting surface increases the leucorrhœal discharge, which is the leading symptom; others are pain in the back and loins, increased by exercise; irregular menstruation; sterility. This condition was long known as ulceration, and supposed to only exist after pregnancy and labor had passed, but erosions are frequently found in the virgin, often the accompaniment of anteflexion. The glandular hypertrophies being of the same nature as the morbid conditions occurring in laceration of the cervix, the essential disease being a glandular growth, erosions frequently develop during pregnancy, and continue, often increased after the lying-in, especially if there is any laceration or subinvolution, as one of the sources of slow recovery. Where there is a high grade of induration and the tissues crowded with cysts, the appearance very closely resembles incipient cancer.

The catarrhal discharge which directs the attention to erosions may be the only indication of a morbid state of the system; in other cases there is a constitutional disturbance, such as tuberculosis or anæmia. In either instance it is an important matter

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and merits prompt attention. Suffering is not sufficient discipline for any woman to warrant a condition tending to exhaustion to pass unnoticed if possible to remove it. Our methods of relief are many. Very much depends upon dress. It should be suitable in quality and arrangement. The diet which affords the greatest nourishment is demanded. Regular exercise is desirable. Mental occupation which diverts the attention from the bodily ills is highly important. Constitutional remedies, as wisely selected as your greatest devotion to homœopathy may enable one to choose, will be required in every case.

Besides, there are adjuvants, or shall we call them surgical dressings? As in the treatment of burns, ulcers and other denuded surfaces, so here topical applications are useful. As a means of cleanliness and as a protection to an irritated surface some dressing is necessary. Hot vaginal douches properly given remove the accumulations of mucus and stimulate the tissues reached. A large number of cases are benefited by use of tampons and glyceroles of ham., bell., aloes, eucalyp., calend., pinus and hyd. When there is intolerance of glycerine the cerate or dry powder is of service. Some patients are so sensitive to any pressure that a piece of old linen or patent lint, placed over the os to retain the powder a sufficient time, is the only application that can be used without producing an irritation of the nervous system. The substance used for tampons depends upon whether there is prolapse, or any form of displacement, connected with the erosion. Cotton, wool, oakum, lint, linen, are all valuable. Of the powders used none are more efficient than some of our triturations, viz., kali bi. 3x, merc. sol. 3x, ars. jod. 3x, hyd. 1x, graph. 3x, and phytol. 2x, especially if indurations and retention cysts are present. These applications should be made every three to five days.

Where slight lacerations of the cervix, with erosion of the mucous membrane, are attended by erosions, I have seen excellent results follow the method of Dr. Helen Maltbie. It is especially adapted to persons whose circumstances seem to prohibit absence from work long enough for the ordinary operation. After the preparatory treatment of hot douches and other measures, all tenderness of the surrounding tissues is removed, an

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application of pure carbolic acid is made to the angle of laceration, tampons profusely saturated with glycerine placed over the tissues and left for two hours, when there is an appearance of a clean cut surface; then the lips are brought together, and the vagina packed so as to keep them in apposition with calendulated glycerine tampons; this remains three days. The first day the patient does not move; the second day she can be on the lounge; the third day about the room, and then carefully resumes her usual work. The rent heals by first intention, and with that the erosion disappears, and renewed strength encourages the sufferer. The form of application is as difficult to prescribe as the internal remedy, and can only be chosen after seeing the existing condition.

Bennet considers erosions among the causes of excessive nausea and vomiting during pregnancy. I have had several cases where extensive erosions existed. The patients reported that during one or two pregnancies the nausea and vomiting had rendered life a burden, notwithstanding the efforts of an experienced, skilful, homœopathic practitioner, the discharge and exhaustion remaining after recovery. The erosions yielded to treatment, and the following pregnancy progressed through the term with none of the former annoyances.

CERVICAL ENDOMETRITIS.

BY T. M. BULICK, M.D., ALTOONA, PA.

THE cervical portion of the uterus, being the most exposed as well as the least vascular and less highly organized part of the organ, would seem to be a cause for its being so frequently attacked with disease. Among the most frequent diseased conditions to which this portion of the uterus is liable to be attacked is that known as cervical endometritis; although not in itself a disease of a dangerous character, it proves the starting point for some of the most serious uterine disorders. The

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causes of this malady are very numerous. It may result from any influence which will produce mechanical injury to the cervix, as displacement of the organ, which may force it against the pelvic walls, the use of ill-provised pessaries, efforts at preventing conception, or producing abortion; laceration of the cervix, the use of caustics, a want of proper attention to the rectum, by which it becomes overdistended, making pressure upon the cervix, the recumbent posture for an insufficient length of time, as well as too early return to the marital relation after parturition are frequent causes; anything specifically exciting inflammation, as exposure to cold or wet, particularly during or immediately before or after menstruation; it may occur from vaginitis or from small polypi in the cervix. There are many other causes which might be enumerated, but these are among the most common causes which are productive of it. This disease is most frequently met with in the chronic stage; it may exist for a length of time without giving rise to any symptoms sufficiently severe to attract the attention of the patient, but in the majority of cases it will not exist long until the following symptoms begin to develop. Bearing down or dragging sensation about the pelvis, pain or aching in the back and loins, worse when on the feet; profuse leucorrhœal discharge, often irritating the vagina and vulva. Menstrual disorders will soon appear, the discharge sometimes being insufficient, at other times too profuse; the interval sometimes being too short, at other times too long; sometimes attended with more or less pain, although this is not usually the case, as dysmenorrhœa is not often caused by disease strictly confined to the cervical mucous membrane. Constitutional symptoms soon begin to appear; the patient will become nervous and often hysterical, the appetite will diminish, with feeble digestion and impaired nutrition. Further on in the course of the disease, other complications may develop, as cystitis, corporeal endometritis, and cervical metritis, which may prove troublesome; pain during intercourse is a common symptom when the latter complications have developed; upon examination we find that the touch reveals a tumefaction with tenderness of the cervix; the external os will usually be found patulous, with the womb very low in the pelvis; a thick, glairy,

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tough mucous discharge will be found oozing from the os; the tissue usually presents a swollen appearance, frequently of a dark red hue.

Treatment should be both local and constitutional. The patient should be removed from under the influence of all exciting causes; as menstrual derangement, tight clothing, or ligatures about the body or limbs, excessive sexual indulgence, uterine displacement, constipation, dysmenorrhœa, any kind of exercise that will be wearisome or tiresome to the body, as rough riding, or long walks, or standing on the feet, the wearing of ill-provised supporters or pessaries. The diet should be nourishing, especially in patients with scrofulous and catarrhal tendency, where the assimilative functions and the blood is below the normal standard. It may be quite difficult to select suitable diet for each individual case (but it is quite as necessary for the cure of the disease as the selection of suitable remedies). The articles of diet best adapted are milk, cream, eggs, beef, mutton, oysters, fish, fowl, game, broths and soups of different kinds, when not too strong or greasy. Cod-liver oil may prove beneficial in some cases. All kinds of stimulants should be kept from the patient, while acid drinks are sometimes useful. Fresh air is always beneficial; mild out-door exercises, in many cases, as buggy or carriage riding over smooth roads, and boat riding, are highly beneficial. For the purpose of cleanliness vaginal injections when used cautiously are useful. A very common and a very useful application to the inflamed cervix is found in the cotton tampon freely saturated with pure glycerine and placed well up against the cervix, which causes a free discharge of serum from the engorged capillaries, thus removing a cause which tends to perpetuate the disease; this application may be repeated, according to circumstances, two or three times a week, except during the menstrual period; a small probe armed with soft cotton wool and well soaked in pure glycerine, may be introduced into the cervix, and allowed to remain for a minute or two, when it may be withdrawn, renewed and reapplied, thus bringing it in direct contact with the greater portion of the diseased cervix. In the selection of proper remedies to meet each case, we must necessarily be governed by the individual circumstances connected with that case, for instance. If the

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endometritis is secondary to an attack of cold or catarrhal fever, the proper remedy might be found among those best adapted to the cure of that cold or fever; so likewise if it occurs in scrofulous, catarrhal, or syphilitic patients, we should give due attention to such remedies as would most likely prove curative in those diseases. But the most prominent indications for remedies will be found in those symptoms which are connected with and dependent upon derangements of ovulation, menstruation, the hepatic, the digestive, the respiratory, the circulatory, and the nervous systems, as well as of the bladder and rectum. By observing the above method of selecting remedies, and keeping in view the other suggestions referred too, we will be able in a large majority of cases to give untold relief, and in many instances to effect a permanent cure.

VAGINISMUS.

BY J. W. THATCHER, M.D., PHILADELPHIA.

VAGINISMUS or spasm of the sphincter vaginæ; but more properly defined as a neuralgic condition of the nymphæ or adjacent structures; a true hyperæsthesia of the nerves of the parts supplying the vulva and vagina, giving rise to an exquisite sensitiveness of the parts of contact, together with spasmodic contractions of the muscles of the vagina sufficient to prevent marital intercourse or physical examination without the aid of an anæsthetic.

This condition is most frequently met with in women of a highly nervous hysterical organization.

Authorities are at variance regarding local causation. Some attribute the seat of trouble to be in the ovary, uterus or rectum; while others believe the lesion to exist in the hymen, and advise its removal by surgical operation in order to effect a cure.

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In Emmet's work on Gynecology he says, "He has never failed to find some local condition, as dysmenorrhœa, limited cellulitis, fissure of the rectum or bladder, etc., as an existing cause." He also says, "When it is due to local inflammation from uterine discharges, the treatment for the removal of the discharge will rarely relieve the vaginismus."

Sims's operation for the removal of the hymen and the insertion of a glass plug until the parts have fully healed, has, according to authorities, more generally resulted in relieving the nervous condition without effecting a cure.

Forced dilatation of the vagina cannot be depended upon as a curative procedure, as we have testimony of its return in a number of cases after confinement.

Laceration of the perineum has been attributed to the tonic spasm of the muscles during the expulsive stage of labor, when vaginismus existed in an aggravated form.

Whatever may be the exciting cause—tender cicatrices of the perineum, an inflammatory state of the vulva, vagina, or the cervical neck, or from reflex irritation from hæmorrhoids, seat-worms, or other abnormal conditions—the unfortunate sufferer, especially if she be married, cannot fail to be most miserable, when relations are interfered with as a natural result of this affection.

Certain cases may require some additional mechanical treatment; but as true followers of the law of *similia*, it is our especial duty to carefully individualize the remedy suited to the case, not from a diagnostic standpoint, but upon purely symptomatic indications for the remedy, which will not only bring relief but a positively curative result. This is exemplified in a case unique of the kind, which came under my care some years ago.

Mrs. G——, age 24 years, has been married a little over two years; is of a highly nervous hysterical organization, and always suffered great pain from the first inception of her periodic sickness. She never could tolerate the least pressure upon the external generative organs. Consequently was unable to make use of the usual appliances during her monthly sickness.

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Some months before marriage she consulted a specialist, who, after an unsatisfactory examination owing to her unwillingness to take an anæsthetic, advised her to remain single, saying, "She could never fulfil the duties of a wife."

The advice was unheeded, and, after two years of suffering and distress, she became a patient of mine. I got a history of disappointment and regret natural to a true woman so situated. Coition had never been successfully performed, and for months past utterly abandoned on account of the extreme suffering caused. Her monthly period was attended with violent spasmodic pains sufficient to cause unconsciousness. She could not tolerate the slightest contact of the vulva, and would not consent to an examination under an anæsthetic.

I prescribed, according to the symptoms, platinum 200th, one dose at the end of each week for a month, and an abundant amount of saccharum lactis between times to satisfy her of my earnest interest in her case. Her next menstrual period was passed without so much pain and no loss of consciousness, and a very marked improvement in the hyper-sensitiveness of the vulva. I discontinued all medication except sac. lac. at long intervals until after the time for her next period, which did not come on as usual; but she now complains of nausea in the mornings, a disgust for foods, etc., and is decidedly a good subject for pulsatilla, which modified her troubles until the end of the nine months, when it was my pleasure to deliver her of a fine large boy.

I have positive knowledge of this lady's history for five years after the birth of this child. She never had any return of her former troubles, and was then the mother of three children.

I have frequently had other cases of mild form where the parts were decidedly tender to pressure, where coition was dreaded, and followed by great aching and soreness with burning, and can attest the value of sepia, silicea and sulphur, together with calcarea carb., caulophyllum, causticum, china, lycopodium, and other remedies when symptomatically indicated in a given case.

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THE INFLUENCE OF GONORRHŒAL INFECTION IN THE DEVELOPMENT OF PELVIC DISEASE IN WOMEN.

BY B. FRANK BETTS, M.D., PHILADELPHIA.

BEFORE the adoption of antiseptic measures made it possible to open the abdomen, and examine the pelvic organs by direct inspection and palpation without fatal results, the origin of pelvic inflammation was shrouded in mystery, in a vast majority of instances. It is true, we were able to trace pelvic cellulitis or peritonitis to traumatic influences in some cases, but we were unable to account for the fact that the same influence produced serious results in one instance, and not in another; and there remained many cases, for which no cause whateverof this character could be assigned, until it was found that the Fallopian tubes were the first to become involved in the inflammatory process, and that, through them, septic material passed to the pelvic peritoneal cavity, and kindled a serious peritonitis.

In consequence of the increased weight and displacement of the tubes and ovaries, incident upon the inflammatory process, or because of preëxisting prolapsus of these organs, they have often been found distorted and bound down in an unnatural position, so that their functional action was seriously impaired, or entirely destroyed; and, when the acute symptoms of pelvic peritonitis had entirely subsided, and the lumen of the tube remained pervious, so that it becomes possible for the woman to conceive, everything has gone on to a satisfactory termination of gestation, but, following *parturition*, a serious or even fatal rekindling of the old, inflammatory process has occurred from the breaking up of old adhesions, or the bursting of an abscess during labor.

Post-mortem examinations, as well as abdominal sections during life, make it apparent that preëxisting pelvic peritonitis only awaits the trauma of childbirth to develop a fatal puerperal peritonitis in many cases.

With the extreme suffering due to an acute attack of pelvic peritonitis, disturbances and pain induced in consequence of the

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cyclical recurrence of the menstrual function, and the dangers incurred after parturition,—all taken into consideration, what wonder that Fallopian salpingitis, with its attendant pelvic peritonitis, has come to be considered one of the most serious infirmities that can befall the sex?

It behooves us, therefore, to inquire into the origin of these affections, and, because it is so frequently left out of consideration, I desire to call your attention, at this time, to *one* source, from whence I believe these diseases originate in many instances, and that is *gonorrhœal infection.*

I do not wish to be understood as saying that gonorrhœa is the *only* cause for Fallopian disease, for the causes are numerous; but gonorrhœa is one of the important causes, in my estimation, and I think the whole profession should recognize it as such.

Authors have, until recently, treated of this affection in women as being of minor importance, and, when Van Buren and Keyes asserted that "gonorrhœa sends more to the tomb than syphilis," we did not apply the statement to women, but, in the light of our present knowledge, it is to them that it is especially applicable.

We can all understand how the Fallopian tubes become diseased, during an acute attack of gonorrhœa, by an extension of the inflammatory process from the uterine mucous membrane, and how the secretions from the tubes may be expelled through the fimbriated extremities and into the peritoneal cavity, and cause septic peritonitis; but we have been slow in believing the theory of Dr. Noeggerath that an almost imperceptible, gleety discharge from the male can be capable of causing disease in the female, without developing in her any of the acute symptoms of gonorrhœa, and it is to this point I desire to direct your attention especially.

It was in 1872 that Noeggerath asserted that, in 90 per cent. of the cases, gonorrhœa remained uncured in males. Of course, he referred to the ordinary run of cases, treated in the usual way by local means, almost exclusively. He furthermore says: "Of every hundred women who have married men formerly affected with gonorrhœa, scarcely ten remain healthy."

Perhaps, in every instance, the husband believed himself to

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be cured of gonorrhœa before he infected his wife. In most instances, it is likely that he was assured by his physician that then there was no danger of such infection; but Hahnemann had written, long before that, to the effect that "the local disease may either be removed or disappear of itself, without the internal disease leaving the organism either in part or entirely; on the contrary, the internal disease may increase in the progress of time, unless it is cured by art;" it was Noeggerath who called attention to the *infectious* nature of the vital fluid of the male after all palpable traces of gonorrhœa had disappeared, and it is for us who reap the benefits of these observations of former times, to endeavor to explain them.

To account for the symptoms of disease, especially of those that are infectious, we must conclude that some influence is at work to produce a change in the vital activity of the organism, which permits or induces a disintegration of preëxisting complex compounds in the body, a splitting-up of histological elements it may be, and, consequently, a degradation of tissue. In some instances this change precludes the possibility of exactly similar results following like causes in the future, as when an attack of measles prevents the contagion from inciting its specific effects at subsequent periods. In many instances a specific influence (perhaps a pathogenic micro-organism) gains admittance to the body, and, finding the conditions favorable for its growth and development, elaborates a chemical poison, which induces its characteristic effects, which are the symptoms of the disease. These materials we call ptomaines and leucomaines.

In a gonorrhœal infection the causative influence may be the cocci of Neisser—the gonococcus, as it is called; or the influence may originate from the ptomaine or leucomaine with which the cocci are associated. A ptomaine is a chemical compound, formed during the putrefaction of organic matter, whilst leucomaines are found in the living tissues, either as the products of fermentative changes, or of retrograde metamorphosis. Some of these bodies are extremely poisonous, producing not only local irritation, but profound, systemic disturbance, and so fine is the line drawn between noxiousness and inertness, that the abstraction of one atom of hydrogen and one of nitrogen, with

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the addition of one of oxygen, converts the ptomaine neuridine which is inert, into neurine—a virulent poison to the tissues. May not some such principle, in imperceptible quantities, be associated with the seminal fluid deposited by the infected individual at the mouth of the uterus, where it meets with an alkaline mucus, that favors its development, without producing any perceptible effect upon the vaginal mucous membrane or external organs of generation? And, as the ptomaines affect the nervous system quite as profoundly as the mucous tract locally, may not the latent gonorrhœal virus produce an impression upon the whole organism of the female, as well as induce its specific effects upon the endometrium and Fallopian tubes, and thus induce general systemic disturbances, or develop the sycotic taint of Hahnemann, in consequence of the influence upon tissue-changes throughout the body. The effect produced by the latent gonorrhœal virus, is much more marked in some cases than others. This is the case with all forms of disease. How often, in witnessing the conflict between health and disease, do we find the victory sway to one or the other side as the condition of the patient changes from extraneous causes, just as an ulcer will now grow smaller and then grow larger again, in direct correspondence with the constitutional weakness or strength of the patient.

Grauvogl found the acute form of the gonorrhœal disease developed the most pernicious symptoms in the hydrogenoid constitution, that is, a constitution that feels every change from dry to wet; that cannot tolerate sea-air; that feels the best on a dry day. It is in this soil that he claimed the virus developed its most baneful effects, and, to cure the disease, he found it necessary to change the soil by constitutional treatment, and natrum sulphuricum and thuya were recommended. The sycotic constitution of Hahnemann calls for sarsaparilla, pulsa., kali bi. and other remedies.

If we have to deal with an occlusion of the tubes with a collection of serum within the tube-cavity, apis 3 will often help to remove it. If of gonorrhœal origin, this collection in the tubes is likely to be pus, however, when kali c., hepar, mercury, lachesis, or Schüssler's calc. sulph. may help, but in cases of long

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standing, when we find the tubes distended, tender and displaced, with peri-ovaritis and its attendant sterility, an abdominal section for the removal of the diseased appendages of the uterus will be the only means of cure.

In many cases, such patients will tell us they were perfectly healthy until they were married; soon after this, they began to complain of pain in the region of the ovaries, the menses became profuse and afterwards scanty perhaps, and the intermenstrual period was marked by a leucorrhœal discharge, which the physician believed to be dependent upon a cervical catarrh. Uterine and ovarian displacements ensued, and with the pelvic organs in abnormal positions, adhesions were formed, leaving no hope of escape from a state of chronic invalidism, except through an operation which must seriously imperil life.

Such patients have either experienced a rekindling of pelvic inflammation in consequence of traumatism, or, upon assuming the marital relation, have become infected by septic germs, which have carried with them potent influences for evil. If the confidence of the husband is gained, we shall often find that, long before marriage, he became infected with gonorrhœa, but he supposed he was cured of the difficulty, until he is informed of the injury he has innocently inflicted upon his innocent victim; and when we recount the diseases which it is believed latent gonorrhœa is capable of engendering, what remorse an affectionate husband must feel in the contemplation of the fact, that he has failed, in what every man will recognize as his first duty towards woman, to shield and protect her from harm.

Whilst every female may not suffer the ills we have mentioned as liable to occur from latent gonorrhœa in the male, the great danger of such infection must make us consider carefully the question, whether or not any man, who has once had gonorrhœa, should be permitted to marry a woman, upon whom he may entail so much suffering and its attendant, sterility; for, surely the law should be invoked to protect what common humanity cherishes the most, *health*, during the time allotted us to labor in this life, and *offspring* who shall, in old age, make smooth the pathway to the grave.

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THE REPORT OF THE BUREAU OF PATHOLOGY.

THE report of the Bureau of Pathology was presented by the Chairman, Dr. W. K. Ingersoll, of Philadelphia. It included the following papers:

Anatomical Lesions of Inveterate Intermittent Fever, by J. C. Morgan, M.D.

Neoplasms, and their Genesis, by W. K. Ingersoll, M.D.

The Pathology of Renal Calculi, by Joseph Rodes, M.D.

ANATOMICAL LESIONS IN INVETERATE INTERMITTENT FEVER.

BY JOHN C. MORGAN, M.D., PHILADELPHIA.

MOST physicians of our school have discovered difficulties peculiar to the treatment of intermittent fevers. I am persuaded that there are two principal reasons for this. First—the cases are not duly individualized, and are treated in a somewhat routine manner. Second—the lesions developed, in persistent cases, are rarely discovered and taken into account.

I further believe that the first-named error is in large measure due to the second; for nothing awakens the average medical mind to individual characteristics, as the clear perception of the anatomical alterations associated with, or provoking them.

Close observation leads me to assume, initially, that a pronounced chill-stage, rarely an early event, is never seen without a continuing venous lesion, before or after, as well as with it; this consisting, *primarily*, of turgescence of the whole portal system of veins, and secondarily, extending to the systemic veins. The origin of portal turgescence is, I am assured, due to *surface irritation*, altogether—from "malaria," of course—whatever that may be; and propagated, through reflexes of the vasomotor nerves, to the contractile arteries—resulting in *spasm* of these vessels.

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The valveless portal veins must, *nolens volens*, accept *the largest part* of the contents of the spasmodic arteries, and retain and increase, from day to day, a residuum of this blood, beginning, early in the case, before the *external* coldness confers upon this stage the name of "chill;" and thus, also, after this is over —and even during the fever and the sweat and the apyrexia, the portal turgescence still continues to persist. Thus, the so-called chill, and the pronounced periodicity, are only the occasional coincidences of the basic portal venous lesion—or rather, the evidences of a special aggravation of that lesion. From first to last, the essential thing is the venous lesion referred to—and out of it arise a considerable variety of *localizations*, at first neuro-vascular only, but later, causing structural alterations of the mucous membranes of the abdominal viscera, and of their connective tissue; and likewise of the venous tissues themselves—particularly in the *spleen*.

The resulting organ-changes are numerous and serious; but owing to the non-arterial quality of the turgescence, it easily subsides to the minimum, after the febrile redistribution of the blood has been effected; and the pyrexial signs of inflammatory processes are hence inconstant and evasive. Nevertheless, they are surely progressing, all the while, but insidiously. The "rational" signs are scarcely ever pathognomonic—hence, the so-called "irrelevancy" of such "symptoms," and the lack of obvious meaning of the time of thirst, or no thirst, of headache, and of conditions of "better and worse," etc.

Many of these irrelevant symptoms, and their relation to specific drugs, become, for the scientific eye, illuminated by a careful *physical exploration*, and the reading of nature's imprint of anatomical alterations, developed along with those symptoms; in other words, bringing the flat picture of recorded subjective symptoms into relief, by the lights and shades afforded by the altered anatomy, the so-called objective symptoms. No doubt, there are many amongst us, who, having a genius for differentiation of the most subtle subjectivism, can seize the salient symptoms which will lead to sound prescriptions, yet it must be remembered that the world furnishes to every profession only a minority of genius, but a great majority of willing plodders, who,

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in the long run, must do the bulk of the world's work. To such, the homœopathic school is largely indebted—as well as to the others. To such, diagnostic *methods*—palpable signs—material phenomena—are essential to thought, and to success in practice. If ignorant or inattentive to these, they are at sea; if these be grasped, however, they become endowed—even inspired—for the work in hand. To such—that is, to the majority of homœopathic physicians, therefore, I repeat—always, in intermittent—indeed, in all fevers—attend rigidly, from day to day, to physical exploration! Yet always grasp the less material characteristics as of essential importance in drug selection.

Firstly, I will mention that index of progressive lesion in general, *thermometry*. I would, *if possible*, have made a careful record of temperature, for every third hour of the twenty-four—the subnormal as well as the supernormal; and the same, in the provings of drugs; for as yet, we know little of what is going on in such cases, aside from the paroxysmal heat; whilst the little that we do know has revealed some surprises; for instance, the rise of temperature which *sometimes* precedes a chill by several hours;—with, of course, a correspondingly early advance of the unthought-of lesions of organ-tissues.

Secondly—*the tongue*. This is, indeed, an eloquent spokesman for all of the suffering viscera! Its alterations are not all of well-understood meaning, however, and they lack nothing requisite to intricate variety. Every such variation should be studied, and its language read—its pathological association with each organ clearly seen—the prognosis deduced—and the more or less similar remedies found, from which to select the similimum. Thus, we may consider all the principal viscera, in connection with the tongue.

The most constant of all the abnormalities is a *furred tongue* varying from almost imperceptible opacity of the surface to a shaggy and dense coating. The former belongs to generalized, rather than localized irritation, and is so common a symptom, along with slight ill-health, as to be commonly disregarded. In my experience, it indicates *gelsemium*, associated, as it often is, with the other indications for that drug. If these be absent,

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some other remedy, suiting the tongue also, will of course be preferred.

As such a slight coating usually means a light case, so the shaggy tongue means, often, a grave, sometimes a "pernicious" one. There is no single drug known to me which is always paramount, here; but I think that one which shows a decided relation to splenic irritation (which is invariably to be sought for), will usually be required, against such a coating; as, *chin. sul.*, *bry.*, etc.

Other organs of the sub-diaphragmatic group have also distinct relations to the surface of the tongue; particularly, as everybody believes, the stomach and liver; and, I think it important to add, the pancreas—although the connection is less easily demonstrated. It is important to remember that in its minuter structure, this gland possesses some of the traits—*e. g.* the closed acini—of the liver, along with those of the salivary glands, to which latter it is more commonly likened. Its secretion, also, is equally complex, and its symptoms ambiguous. Its locality, however,—across the upper lumbar region—is the frequent seat of pain, which should always call attention to it; whilst *late* or intestinal digestion must always suffer when this organ is faulty, whether the fats, or the starches, or the albuminoids prove indigestible.

An acute catarrhal state may occur, requiring *acon.*, *bry.*, *merc.*, *bell.*, *nux v.*, *sulph.*, or *natr.*, *mur.*

An *interstitial* inflammation may exist, calling for *ferrum phosph.*, *kali mur.*, etc. Such a lesion would be comparable with cirrhosis of the liver or kidney, and rather belongs to a more chronic state. Pancreatic function is intimately connected with hepatic function, as the secretions emerge together into the duodenum; and this part of the intestine is usually involved with *both glands*, mostly in a joint catarrh, when either appears disordered, in acute disease, malarial or otherwise. The pancreas is, however, peculiarly related to the digestion of *fatty* foods; hence, when these disagree, we may rationally blame this organ; and the drugs which are homœopathic to such disagreement may be thought of as pancreatic remedies, in part; as, *pulsat.*, *nux v.*, *sep.*, *natr. mur.*, *carbo veg.*

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The stomach relates, of course, more particularly to *early* digestion; and its state is commonly held to be faithfully mirrored by the tongue. It is probable, however, that many of its symptoms, as well as those of the tongue, are indirect—secondary to nervous, hepatic, and splenic disorder. *Original* gastric symptoms are not rare, nevertheless, and are most frequently nervous, vascular, muscular, or catarrhal, with collateral symptoms demanding respectively such drugs as *ipecac*, *gelsem.*, *nux v.*, *puls.*, and *natrum mur.* The tongue is likely to betray upon its surface, or in its shape, movements and sensations, the very same sort of morbid alterations which the stomach itself suffers from, so far as we may judge, in view of the not distantly associated nerve-supply; wherefore, in purely gastric cases, we may read much of the stomach upon the tongue. The various readings are well summarized in works on clinical medicine, and by Raue in his Pathology. These require, with their related remedies, extended and detailed study. Of those above named *ipecac* shows, with constant or very frequent simple nausea, only a thin white coat upon the tongue; *gelsem.*, a reddish tongue, with a slight opacity of its surface; *nux v.*, a somewhat contracted, dry, dark, yet not very thickly coated tongue, feeling like a dry chip in the mouth, with upward flatulence and constipation (like conditions, with *diarrhœa*, indicate *china*). *Natrum mur.*, according to Schüssler, has a typical tongue—catarrhal, whitish, moist, somewhat viscid, with numerous air-bubbles; secretion like white of egg and water. Many other drugs might here be brought into profitable comparison or contrast; but such are easily found in the repertories, to be afterwards minutely studied side by side in the Materia Medica. These few examples, it is hoped, may point the way from the standpoint of the Bureau of Pathology.

The *intestines* sometimes show the most marked localization, with symptoms of diarrhœa or dysentery. These are cured by *chin.*, *nux v.*, *merc.*, *bryonia*. The tongue will, in such cases, usually present evidences of hepatic derangement.

We come now to consider the most important of all the organs involved in "Inveterate Intermittents." Almost always *the liver* and *the spleen*, on percussion, will be found enlarged—

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I scarcely think any case will prove an exception. The liver-dulness, in the line of the nipple, should normally extend from the fifth rib to the lower edge of the thorax, only (misleading careless diagnosticians sometimes to suppose a pulmonary hepatization). When an intermittent has matured the patient may feel discomfort about the stomach, and the complexion and conjunctivæ may be of "bad color" during the apyrexia, but these symptoms are quickly disregarded as mere anæmia, with weak digestion, common to the disease, and indifferent or irrelevant as to drug-selection. Now, however, let the physician carefully explore by percussion the right and left hypochondria, the liver and the spleen. On the right side, in the nipple line, the dulness extends—rarely upward, but pretty surely downward—and there is tenderness below the ribs, and, by the way, the ribs themselves are often sore, showing slight periostitis. The stools are clay-colored from catarrh of the biliary ducts, with swelling, obstruction, and non-escape of bile. The pancreas suffers with a like catarrhal state; and hence, of course, comes impaired digestion; the tongue is tooth-indented, flabby, moist. Now, for all this group of symptoms, the typical remedy is *mercurius*, as old-school empiricism long ago found out, but we, whilst knowing, too often forget. It does not, however, stand alone in the liver list—there are many others, as *lycop.*, *natrum mur.*, *kali carb.*, *china*, *nux vom.*, etc.

Examining the left hypochondrium, we locate the normal spleen by its anterior border and by its upward extension. Anteriorly it should be found covered by the eleventh rib at the distance of a quarter of an inch behind its tip. Above, in the *axillary line*, it is covered by the ninth rib. These are the normal limits of the accessible and distinct splenic dulness. Any swelling of the organ will be shown by the forward or upward extension of dulness, or by both. In the supposed case of inveterate intermittent fever we shall find, in all probability, such an extension. We place the left index finger upon the tip of the eleventh rib, and make percussion with the fingers of the right hand. Normally, the note is resonant, owing to gas in the descending colon. Now it is dull—and the dulness may project even further forward—although we must be cautious not

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to confound splenic with fæcal dulness in that event. If resonant both above and below the interval of circumscribed dulness, it is doubtless splenic.

And what now of the tongue and of other symptoms directly related to the splenic lesion, and the similar remedies? In the first place, continued splenic disease surely destroys millions upon millions of red blood-globules, assisted in this by the liver. Their coloring matter is believed to furnish that of the bile, and through further oxidation the pigments of the urine also. These are at first visibly increased, then wasted by combustion, and deficiency of both groups of coloring matters, of course, ensues. The increase is represented by *gels.*, *bry*, *merc.*; the decrease by *lyc.*, *chin.*, *carbo veg.*, *arsen.*, *nat. mur.*, and also by *mercurius*. Perversion of bile pigment, as in melæna, or blackish stools, indicates *chinin. sulph.*, *ars.*; black urine, *colch.*

Acute and chronic "splenic tumor" (so-called by the Germans) is intensely acted upon by *bryonia*, and this drug should always be remembered; but the other remedies named should be well compared before prescribing; and, among other drugs, *chininum sulph.* and *chininum arsenicosum* are particularly worthy of study; also, *ceanothus*. Empirically *chinin. arsen.* has been employed with marked success in the 3x.

The resulting *anæmia* is seen in the pale, cool tongue, even after all else is subdued. Schüssler and many others rely here upon *calcarea phosphorica* 3x as the great tonic, and not in vain. Schüssler ascribes this action to the stimulus thereby given to the formation of *white* blood-globules, the red ones being subsequently produced from these. In simple anæmia, after any acute disease or without such causation, the late Dr. Bayes, of London (see "Applied Homœopathy"), strongly commended the use of *ferrum aceticum* 2x, specifying most strictly that it be given *immediately after each meal*. I have frequently verified the great utility of this prescription, giving about one-third of a grain, in water, at each dose.

The acute venous affection of the liver, pancreas, spleen, and stomach during the earlier stages is, of course, the principal cause of the inveterate form of this disease, being entirely unsuspected, or imperfectly recognized and treated. Therefore, it

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is most important to begin aright; exploring all these organs early, recognizing the acute lesions objectively, comparing them with the subjective symptoms, and clearly interpreting their connection, then the selection of the curative drug should not be very difficult. In this class of cases *gelsem.*, *bry.*, *ars.*, *ipec.*, and a few others, will perform many cures.

There are still other important lesions to be mentioned. Thus, "rheumatic" alterations of the *muscular tissues* and of their *nervous connections.* Early in the disease *gelsem.* is well indicated by the totality. Weeks later it is common to witness the development of *rhus* cases, which more rarely may involve the brain itself in the region of the lingual nerve; with red-pointed tongue, stupor, rheumatic pains, restlessness of limbs, body and mind; dry, hacking cough during chill. Other more violent brain cases, with frightful delirium, ulcerated tongue, obstinacy, severe congestive headache, etc., occur, and to these *belladonna* is suited, and will be cured by that drug. Again, a numerous class are curable by *bryonia*, having "bilious tongue, vertigo on rising; severe headache, worse upon the least motion, or turning the eyes; much thirst, sour or bitter taste; chills, beginning in the hands and feet, or between the scapulæ. When these symptoms are present, the physical exploration recommended will reveal gastric and hepatic, and sometimes muscular, lesions. In cases simulating these, but in which the patient is peculiarly taciturn and perhaps thirstless, and presents the anomaly of a *pale face during the heat*, *pulsatilla* is curative!

Taciturnity may be termed a "lesion of speech," recognizing, of course, a cerebral origin for this. This may be compared further with *arsenicum*, wherein, with prevailing pallor and weakness, the patient speaks, sometimes with the most exasperating mental weakness, slowness, hesitation, and indifference—the antithesis of *belladonna.* Contrasting this the *belladonna* shows a hasty brain and eager speech. *Ap's*, again, with swelled throat, etc., has *clogged* speech.

It has just been stated that *bryonia* has chill beginning in some cases between the scapulæ. *Tartar emetic* has *heat*, and *china* has sweat between these parts. The nervous association of these with the internal viscera which the three drugs affect

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and with the aching head, will afford another interesting anatomical and physiological study, and all drug-provings gain new meaning when examined in this same light. Grouped with these drugs, in this respect, are many others, of which we may particularize *gelsemium* and *capsicum; gels* has chills beginning in hands and feet, and, again, it sometimes courses from the sacrum to the occiput. *Caps.* has chill beginning between the scapulæ and spreading over the whole body; also chill beginning in the epigastrium; connecting, by the drug-genius, the interscapular nerves with the region of the stomach, pancreas, liver, etc. *Arsenic* has "chill running up and down the spine;" and it is also prominent among gastro-intestinal, hepatic, and splenic drugs. In all the anatomy of the portal system is intimately associated by nerves with the morbid symptoms, as stated at the outset.

The *extra-portal*, or general circulation, however, is by no means inert during the course of intermittent and other malarial fevers. *Periodicity*, that great quality of malarial disease, is not restricted thereto; it is only exaggerated in this class, and that very exaggeration is, I believe, nothing more than the *alternate domination* of the portal and the extra-portal blood-lakes, along with the equally alternate stimulation, diurnal or otherwise, of the two corresponding nutrition-fields in promoting their cell-changes. The expression of periodicity in the portal system is the more boisterous perhaps, but this is evidently due to the violent and sudden tidal changes to and from the extra-portal, such as the cerebral, the thoracic, and sexual organs, the muscles and the skin. *Ordinary* malarial alternations of this sort may be compared with the tides of our own Delaware River, with its seven feet of ebb and flow, whilst the congestive or "pernicious" cases, which fatally inundate the brain, or the lungs in the extra-portal system, or the liver, spleen, and intestinal canal in the portal system, with venous engorgement of the most astonishing degree in either case, may be likened to the mad tidal rush of the waters of the Bay of Fundy, with its thirty to seventy feet of ebb and flow.

In other diseases and in health the portal and extra-portal circulations present less antagonism, less of alternation; yet

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even here a minimum of tidal alternations and "periodicity" is easily observed. Both German and American observations—some of the latter my own—show that there is a normal chill and fever twice daily in health; a major paroxysm in the after part of the day, a minor in the early hours. In ordinary diseases these hours are the same, but the paroxysmal phenomena are more intense with evening fever, etc. Even in malarial fevers *in the beginning* the same is true, and in that lies the subtility of their approach, in many cases being so much like common diseases. To the experienced eye, however, the slight venosity, the langour, the drowsiness, the slight heat, the headache, and other pains, with deficient local lesion as yet, the anorexia, etc., always mean "malaria." The lesions of malarial diseases, as heretofore stated, as a rule are not self-asserting, not fully accounting for the symptoms until an advanced period.

When, however, portal lesions, as herein described, have become really tangible, and thus easily discoverable, although still hidden, the evening periodicity is liable to *anticipate;* afternoon or forenoon paroxysms occur; the violence of the tidal alternations increases; the nervous irritation augments; the lesions of the tongue, liver, spleen, also, and now severe chills and heats, sweats, etc., occur. When getting better the paroxysms get milder and later in the day, and the lesions are found receding, the tongue gradually gets less foul, the liver, etc., etc., less enlarged and tender, and *the paroxysms cease for want of the reason for being;* all regardless of the life or death of "malarial bacilli" of any sort.

The course of *extra-portal* congestion, in such a cycle of events, also affords many modifications of drug-indication, in *particular cases* of intermittent fever, and it is only good sense to keep this pathological influence in view in all remedy selections. For instance, in some cases a tonsillitis may complicate the attack, and here we may find the upper cervical nerves betray sympathy, by the chill commencing in the *front of the chest.* In this mode of beginning *apis mellifica* is a most important remedy, and often cures. The same is true when the chill begins in the *knees;* reminding us that it also has a specific affinity for the lumbo-sacral nerves, and with the genital organs

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and limbs supplied by them. It should here be noted also that these two *apis* regions, including the mammæ and ovaries of the female, are themselves sympathetic.

Again, malarial neuralgia of the trigeminus, vulgarly called "sun-pain," finds frequently its specific drug-counterpart in *belladonna*, which is particularly intimate with this very fifth pain of cranial nerves and its *central irritations*. *Chinin. sulph.* acts not only on this nerve, but as well throughout the spinal system.

We have now passed in review the field of malarial morbid anatomy in those subtle forms which have so often prevented the successful treatment of intermittent fever. May we not then fear that hereby symptomatology will be driven to the wall, and a premium be offered to crude generalization as against individualization? Such a result would be subversive of my aim. I would, on the contrary, give pith and point, and meaning, and memory-help to the study of every minute and individual symptom, by proving the real existence and nature of its material substratum. May this desirable end be reached by all.

NEOPLASMS AND THEIR GENESIS.

BY W. K. INGERSOLL, M.D., PHILADELPHIA, PA.

THERE is one essential fact to which I wish to draw your attention in the consideration of new growths and their origin, *i.e.*, that all tissue, whether normal or neoplastic, has its origin in the connective tissue or epithelial cells, or derivatives from them; that epithelium from the beginning of the life of all organism is epithelium, and the connective tissue is connective tissue; in short, that these two kinds of tissue exist together from the start, separate and distinct cells, and that the cells of one under no circumstances will develop into the cells of the other.

It is easy very early in the embryonic life to more especially determine the epithelial cells from the connective tissue. The

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functions of these two kinds of tissue differ quite widely in the main. The connective tissue is the frame-building substance of the body. The bone, muscle, cartilage, tendon, fascias, and sustentacular substances of the organs, besides the lining of the closed cavities, are formed from it, while the epithelium has the pabulum-forming function, which has to do with ingestion of food, digestion, secretion, and excretion, besides the production of nerve force. The connective tissue forms the frame-work, the epithelium forms the material for its use.

We may say man is the type of connective tissue, with his large frame, strong bones, well developed muscles, and not even enough extra pabulum to fill with fat the chinks between his muscles; while woman represents the epithelial type, slight frame, small bones and muscles, her alimentary tract always forming more nutriment than can be used, and ridding herself every twenty-eight days of an overplus of pabulum, some of this extra nourishment going into the fat that lies between her muscles, making her limbs and body of graceful curves and gentle undulations; lactation is another expression of her greater epithelial activity.

In the embryo, the connective tissue cells are found in the middle germinal layer, while the epithelial cells are in the external and internal layers. There has been a dispute as to the fact of the middle layer containing only connective tissue cells; many histologists contending that there originally were also epithelial cells there. The later developments rather favor the idea of the older histologists that only connective tissue and its derivatives are formed in this layer. The ovum and testes are formed in the middle germinal layer, with probably an epithelial proventriculus from the external layer, entering into the formation of the kidney and genital tracts.

It is only at a late embryonic period that you can determine the sex of the animal by the sexual eminence of the Wolffian bodies. In the germinating testis or ovary you may see a layer of growing epithelial cells, among these cells will be seen some larger oval cells, few in number. These large cells become ova within the stroma of the ovary, each surrounded by small epithelial cells lining the Graafian follicle. In the testis these large oval cells disappear; just how is not known, and the re-

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maining epithelial cells finally become the proliferating germinal epithelium of the adult testis; after undergoing stages of development each cell breaks up into a bundle of nuclear bodies, and is cast off in the sperm as spermatozoa.

An ovum represents a connective tissue cell; it lives in the Graafian follicle surrounded by the food supplying cells lining it, and even after being expelled from the follicles it has pabulum enough to enable it to go on to segmentation. If there is no more food furnished degeneration results. On the other hand, if the nuclear bodies of the epithelial spermatozoa enter, and begin the food forming process, fecundation takes place, and we have life. Hence we say epithelium begins at the moment of conception; so also with connective tissue; one coming from the testes, the other from the ovaries, and the one never being developed from the other. Other things being equal, the greater the vitality of the sperm at the time of conception, and we have the epithelial type of individual formed, a female child, with small bones and muscles, and great pabulum forming power. The ovum being of greater strength, and we have a connective tissue type of individual formed, or the male child, with large bones, strong muscles and lessened power of forming pabulum.

Looking upon the subject from an outside point of view, we will find a rational explanation for the balance of the sexes. Increasing the number of males, sexual connection is decreased, and the vitality of the sperm is thereby increased, as a result more female children are born. On the other hand, you decrease the number of births, you increase the vitality of the ova, and more male children are born. In this way, commercially speaking, the supply in either case equals the demand.

The foregoing is something of a digression, but it may point out the way that inherited tendencies descend from father to daughter, to grandson; or from mother to son, to granddaughter.

New growths are either connective or epithelial tissue. We will consider only the malignant types of each class.

In Germany and England, during the past two or three years, there has been made an effort to connect the malignant types of new growths with the infective granulomata. But thus far

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the results of experimentation have been very barren of conclusive facts, and we, therefore, see no reason for changing our ideas or nomenclature of the malignant growths.

The malignant connective tissue growths are called sarcomas; those of epithelial origin are called carcinomas. Their malignancy depends upon the rapidity of their cell multiplication. In the sarcomas we may truly say that they are composed of rapidly proliferating embryonic connective tissue; but it seems to us that the embryological character of the cells in the carcinomata only consists in the rapidity of their cell increase.

As to the origin of sarcomas the idea that has been held by many pathologists that embryonic tissue remains in the adult organism, and gives rise to these new growths, is the most feasible. The action of these growths toward the surrounding tissue, often growing through muscle and other fully formed tissues without disturbing their cellular integrity, shows that there are no irritating inflammatory conditions associating themselves with the growth in its beginning, to produce the degenerative influence in continuous cells. Gross, after enumerating a long list of statistics says: "These facts show that the etiology is most obscure, since their development is rarely traceable to injury or disease, and is not influenced by hereditary tendencies; while social state and menstrual irregularities or arrest are surely unimportant factors in their production."

The tendency for these neoplasms to occur in early life is rather confirmatory of the theory of embryonic cells after birth remaining dormant in the tissues, which under favorable circumstances (of, perhaps, nutrition) spring into new life and new growth.

In carcinoma we have a growth developing late in life, when the vitality of the system is on the decrease. The character of the cells is not embryonic except so far as cell multiplication goes; any of the cells are adult in size and form, and unlike embryonic cells do not grow upon a basement membrane, or semblance of one, with perhaps the exception of the cylinder-celled epitheliomas of the liver and rectum.

We, from our own observation, and from the general, half-expressed beliefs of the profession, are of the opinion that all

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cancers are produced by a stage of injury, mechanical or otherwise, to the epithelial tissue in which the growth arises.

How often we find an ulcer after long irritation becoming cancerous, a pimple on the face is picked and picked, and in time it becomes epitheliomatous? A short clay pipe resting on what seems to be an innocent crack in the lip, causes a new epithelial growth. Fagge says in his practice, "Many instances can be cited in which a malignant tumor appears to arise out of some chronic local lesion. Thus it is well known that a keratoid cancer sometimes appears in the cicatrix of a burn on the hand or on the arm where such a growth is otherwise rarely seen. A similar affection follows ichthyosis, or white syphilitic patches at the end of the tongue, at the end of several years.

"In the common bile duct, a carcinomatous growth is very frequently traceable to irritation of its mucous membrane by gall stones. And I have seen more than one instance in which a malignant growth in the posterior wall of the bladder has seemed to have been caused by the repeated introduction of catheters."

Gross says, "The effects of past inflammation, such as scars and warts, if they become the seat of cancer, are almost always so situated that they are subject to injury or irritation, and are thus encouraged into cancer, if one may use the term."

We will take an ulcer of the tongue as an instance. Here is going on an epithelial struggle in trying to cover over a solution of continuity in the mucous membrane. Under the unfavorable conditions, of almost constant motion of bad teeth or of the use of tobacco, there is repeated and re-repeated proliferation of epithelial cells, which are in vain thrown out to fill the gap, until the epithelial cells take on a life within themselves and an embryonic activity of proliferation growing without a basement membrane, free from and below it.

We see a whirlwind on a summer day gain strength and force apparently from no source, cross a country road and carry straw and dust into the air. This force is derived from the counter currents of ascending air. Likewise these cells get a vitality from the counter forces of life and death, destruction and repair, and give origin to these new cells with their power.

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THE PATHOLOGY OF RENAL CALCULI.

BY JOSEPH RODES, M.D., PHILADELPHIA, PA.

I HAVE had the good fortune to have under my care for some time a case, which proved, by the autopsy, to be double renal calculi. As we run through the pathology of the disease we shall see how far our theories correspond to facts.

In order to arrive at a proper understanding of our subject we must first quickly review the state of normal blood plasma and of normal urine.

The blood plasma normally holds in solution about eight and one-half parts of mineral salts and four parts of crystallized nitrogenous matter, in the thousand parts of plasma.

Average normal urine is transparent, pale amber in color, distinctly acid in reaction, having a specific gravity of about 1020 to 1025, and contains no decided sediment. In 1000 parts about 950 are water, and the remaining 50 parts, solid matter held in solution.

Both any or all of the mineral constituents of the blood or urine are changed in their ratio one to another by changing conditions of the body as to rest, exercise, food, drink, sleep and wakefulness. There is a diurnal and seasonal change, as well as one modified by climatic influences.

These slight and temporary variations are without question normal, but so soon as they cease to fluctuate, and any *one* persists for a considerable length of time, we pass from the normal to the pathological.

A very important question at once arises in our minds, and requires an answer. What pathological condition is present to determine renal calculous formations? Is it a trouble in the blood, kidney structure, or urine? Let us see.

Just as the blood is the all-important fluid, containing all the elements necessary for the repair of tissue, also many of the waste products of those tissues, which it conveys to the excretory organs, so is the condition of this blood, during its abnormal states, the great important factor in the primary formation

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of calculi. In proof that the blood is the cause of this nephrolithic condition it is possible to correct it by diet, etc.—influences which act on the blood. It contains all the ingredients necessary to stone formation, provided some of the following conditions are present. First of all the blood is capable of holding in solution only a certain amount of mineral matter. Any of the many causes that increase the mineral constituents of the blood favor the deposit of salts in the kidney this side of the tubular epithelia, because here suddenly the ratio of liquid and dissolved solid matter is at a still greater variance.

We have many proofs that the blood is the faulty organ. Kidney epithelia are sometimes found coated with crystallized deposit. In cases where for some reason the kidney does not or cannot rid the blood of the excess of solid matter, concretions may form on almost any mucous membrane. Now there is but a step between the precipitation of these crystals and their combination, by the assistance of another factor, into calculi. This factor is most likely some colloid material, evidently furnished by the epithelial cells of the pelvic mucous membrane or of the renal tubules. I say this colloid material is necessary, because some persons suffer for years with undissolved material in their urine and yet never show signs of calculous formations. Again, the ordinary salts are precipitated more or less in an amorphous state, whereas the kidney stones are usually made up of spheroidal masses of these crystals.

I almost forgot to mention some of the other, though less frequent, causative agents in the formation of calculi, such as some local disturbance of nutrition in the renal pelvis; particles of pus, mucus, or blood clots may be the nidus in which the urinary salts are deposited. Bacteria also fill an occasional place. The researches of our great German investigator, Ultzmann, leave not a doubt in our minds, by his careful examinations of microscopic sections of renal stones, that these substances frequently form the nucleus.

Let us look for a moment if we can find cause for the calculous formations in our patient. Well, first of all, he lived in a country town most of his life, where he constantly drank "pump" or "hard" water. You probably all know that this contains

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mineral matter greatly in excess, so much more than the urine can usually hold in solution. Next, his occupation was a sedentary one. Again, he was a hearty eater, and suffered from dyspepsia for a long time, thereby bringing in another factor—mal-assimilation.

Now, these habits and circumstances do not necessarily mean the production of stone, but are usually present when such exists.

Calculi may originate in the uriniferous tubules, or in one of the calyces; but usually, even when one is started in the tubule, it finds its way into a calyx, or into the pelvis of the kidney, before it attains any magnitude.

There is undoubtedly some etiological factor in the age of the individual, most likely due to the changing ratio between build up and break down. Such deposits occur more frequently in childhood and old age than in middle life, and far more frequently in males than in females.

In infancy the nucleus of a renal calculus is usually formed of urate of ammonia, in young adult life of uric acid, and those formed later in life of oxalate of lime and occasionally phosphates.

Undoubtedly there are certain constitutional conditions which give rise to certain stony formations. Allow me to say a few words regarding several of the calculus diatheses that we fairly well understand.

First, the uric acid diathesis chiefly occurs in stout, plethoric individuals, high livers, and often associated with gout. It is characterized by scanty and high-colored urine, depositing an abundant yellowish-red sediment composed of uric acid in combination with soda, potassium, and ammonia. The calculi that occur in this diathesis are of two kinds: The uric acid calculus, of moderate size, usually smooth, and is the most common of the primary calculi, most likely on account of the fact that uric acid is so sparingly soluble. The second variety is very rare, and made up of urate of ammonia; it is clay-colored, and found chiefly in children.

Now we will speak a few words about the oxalic diathesis. This diathesis is usually found in individuals in whom there is mal-assimilation, depending upon exhausted nervous energy arising from overwork, mental anxiety, or venereal excesses.

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This patient is often just the opposite to the first described. He is thin, poorly supplied with blood, usually a marked dyspeptic. There is usually some debility of the sexual organs; urine is pale, abundant, and acid. The oxalates float in the urine, and only settle after the urine stands for some time. The calculus that occurs is composed of oxalate of lime, often called the "mulberry calculus" on account of its dark-brown or black color and its rough or tuberculated surface. Usually small in size. This, again, is quite common as a primary calculus, because of its insolubility like uric acid.

We will next refer to the third or phosphatic diathesis, also quite common. This and the preceding diathesis occurs chiefly after the fortieth year. This diathesis occurs chiefly in the aged, as we have said, but especially those who are *prematurely* old. The sediment and calculus occurs in three distinct forms: First, where triple or ammonio-magnesian phosphates are in excess; occurs usually in alkaline or neutral offensive urine, and is associated with decided debility. Second, where amorphous phosphate of lime is in excess, usually precipitated from alkaline urine. Third, where the mixed phosphates are deposited in large quantities. This occurs when the urine becomes alkaline from decomposition, sometimes forming a mortar-like sediment in the bladder. It is usually the mixed phosphates that form the incrustations around foreign bodies in the bladder. Pure phosphatic calculi are very rare, either forming the nucleus or the chief constituents of renal stones. They are usually mixed phosphates. First, they would be likely to be secondary formations, *i.e.*, formations resulting from an alkalinity of the urine. We know this state of the urine to be rare in the kidney, as it is most often a sequence of existing stone. On the other hand an alternating stone of uric acid, oxalate of calcium, and phosphates, in distinct layers, is not uncommon.

Perhaps you will think it strange that I should depart somewhat from my original topic. But please remember I said these states were *constitutional* abnormalities affecting primarily the blood, and it is only through its pathological products in the urine and urinary organs that we are enabled to recognize and study them.

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Let us see if we could have diagnosed with some certainty the character of renal stone in our patient from the diathesis he presented. He was most likely under forty years of age when it first started. This would make it doubtful as to whether it was a uric acid or an oxalate of lime concretion. Well, I found he had alkaline urine, and you know that alkaline urine and uric acid stone formation are incompatible. Then this almost throws out uric acid calculi and brings into prominence the phosphatic. But he was not very old; again, *primary* phosphatic calculi are rare. Now, what about his general condition and physique? He was slim, nervous, and a dyspeptic. His build of man would make us suspect oxalic calculi, but remember his urine is alkaline, and with the oxalic diathesis we have acid urine. So far facts seem to upset theory, do they not? Probably we have not looked deeply enough. Let us ask his physician of years ago what was the reaction of the urine when he attended him for symptoms similar to those for which I was called in, and he answers, acid. Now the prospect for a diagnosis seems more certain. We would say the greater part of his stone is composed of oxalates, while the outer coating is mostly phosphatic. And why this change of constituents—quite evident? The long-continued presence of the rough stone set up a pyelitis, which changed the reaction of the urine from acid to alkaline. This recalls to my mind a distinction of much clinical importance between primary and secondary stone formations, the difference being that those of primary formation are composed of substances which may be deposited from urine, whose only abnormality is a relative excess of solid ingredients; such are the concretions of uric acid and urates, oxalate and phosphate of lime. Secondary stone formation results from a previous alkaline fermentation of the urine, consequent upon diseases of the bladder or pelvis, whereby several substances, chiefly earthy phosphates, the urate of ammonia, and the triple phosphates, are produced and precipitated.

We will now see if our stones agree with our diagnosis. Both are slightly irregular, although the irregularities have been largely rounded off by the deposition of phosphates. The stone from the right kidney weighs 570½ grains; that from the left,

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454 grains. On section we find them made up of concentric layers, as is most common; the dark-brown or nearly black oxalate of lime being in excess, thereby naming the calculi; the remaining layers being made up of uric acid and phosphates.

What are the effects of renal concretions on the kidney? These effects are determined by the size, form, position, character of surface, composition and age of the calculus. A stone, as large as a marble, rough and sharply mammillated upon its surface, may remain confined to one of the calyces for years, without giving rise to more change than induration of the whole organ, due to slight, chronic, interstitial inflammation. On the other hand, quite a minute stone, perhaps not larger than a mustard seed, if in the tubular structure of the kidney, will excite congestion, inflammation and abscess. After a calculus becomes too large to pass through the ureter, particularly when its surface is rough, it acts as a local irritant to the mucous membrane lining the pelvis, giving rise to inflammatory redness, multiple spots of ecchymosis and slight extravasations of blood due to congestion, mechanical injury, and later to ulceration from the presence of the stone. This is followed by a catarrhal state of the lining, characterized by shedding of the epithelia of the mucous membrane, constituting pyelitis, in which there is poured into the pelvis of the gland, first, mucus, and, later, a muco-purulent material. When the stone is of large size, filling the renal pelvis, or small enough to fall into and close the ureter, certain symptoms result from the damming back of the urine on the kidney structure. The pelvis becomes more distended, encroaching more and more on the renal parenchyma, resulting in its destruction, and final conversion into a hydronephritic sac. In other instances, whether there be obstruction or not, the pyelitis spreads to the renal tissue, producing consecutively a catarrh of the medullary portion, an interstitial and suppurative nephritis, finally ending in complete destruction of the gland, peri-nephritis and extra-renal abscess.

We will now return to our specimens, and see if we can judge, after examining their present condition, what stages they have gone through, and the length of time it has taken. To be more

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thorough in our examination, we will look at the kidneys separately, and, if possible, ascertain, which was affected first. The left kidney presents a decided, distorted appearance from the outside, the pelvis large and sacculated, kidney structure atrophied, irregular in contour, and capsule adherent. The ureter resembles very much a clay-pipe stem, as regards the relative thickness of its wall, compared with the size of its lumen. On section longitudinally a large quantity of sanious, stinking pus, loaded with earthy salts, escapes. The pelvic wall is very much thickened, and its cavity decidedly overdistended, and contains a stone, oval in its general shape, about one and a half inches in its longest diameter and about one in the other, except at its upper and cortical aspect, while *in situ*, where there are two quite prominent projections, neither of these fitting into the uretal opening, but both into inverted, papilla cavities, of which I shall have something to say, later on. Opposite the uretal opening, the stone is somewhat roughened, thereby allowing the urine to escape quite freely. The renal parenchyma presents a picture of chronic, interstitial nephritis, besides being channelled in every direction with pus cavities containing the same character of pus that was found in the pelvis. From one special appearance I judge, when this stone was much smaller than it is now, it did for awhile occlude the ureter, more or less. Later on, it became more irregular, or the tissues around yielded, so that, just before death, at least, urine flowed around the stone. My reasons for thinking that there was obstruction at one time, is that the following pathological condition is present. The papillæ or apices of the Malpighian pyramids, instead of projecting into the calices of the ureter or pelvis, as they do normally, are obliterated, and cavities take their place. The pressure of pelvic fluid must have been of considerable force and persistence to have turned inside out, as it were, these nipples. The right kidney presents an identical picture, except it is far advanced in the degenerative process, and the stone is larger and smoother.

The history of our patient's early trouble in the urinary organs perhaps will throw some clue as to the relative ages of the stones in the right and left kidneys. About twenty years ago, he first experienced trouble with his bladder and kidneys. Three

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years later, although the first trouble had not entirely passed away, he had a decided aggravation of those symptoms, and this time they pointed more to the left side.

Now, as to the early diagnosis of renal concretions by a pathological condition of the urine—a question of no little importance, as it allows of a nephro-nephrotomy, in place of the old-time nephrotomy, or even nephrectomy—the saving the patient many hours of suffering, and, above all, leaving behind a useful and healthy kidney.

Undoubtedly stones sometimes exist without causing any noticeable symptoms. But the cases I ask for an early diagnosis are those exhibiting vague bladder-symptoms, which are intelligible only to those who work long and late with their microscopes and in their laboratories.

This is a question rather difficult to answer, yet it is often demanded by our patients that we be well-nigh certain, as on our decision hangs the duty of operating or not operating.

First, as our guide, we have one of the diathetic states, and its more or less characteristic urine-sediment. Although one may be the subject of one of these calculous diseases for a long time, and never be the subject of renal stones, yet we probably seldom have a renal calculus existing, without a pre-existing, corresponding diathesis, showing itself at times at least. Another symptom is blood. This, the chances are, will be a symptom that will come and go. Of course, I refer to blood that comes certainly from the kidney, which can be proven by washing out the bladder carefully, and catheterizing the ureters almost direct. Remember, its presence sometimes can only be detected by the microscope. Now, what else would we expect to find from the presence of the stone? Increase of mucus—the first symptom of catarrh. Shedding of the spheroidal epithelia of the pelvis. Sometimes quite early pus, and again let me caution you—pus from the kidney. This pus of pyelitis, occurring in acid urine, is not stringy, and separates readily from the urine, on standing.

Add to these all the subjective symptoms, and you can quite reasonably and certainly suspect renal calculus or calculi.

As to the diagnosing to a certainty as to which kidney is the seat of the trouble, the only guides I know of are: pain, more or

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less constant on one side; tumor; by the performance of the operation known as "needling"—multiple puncture through kidney-area with an exploring needle; last, and not least, and quite justifiable and safe in most cases—to cut down on the kidney, and palpate or even open its pelvis.

THE REPORT OF THE BUREAU OF CLINICAL MEDICINE.

THE report of the Bureau of Clinical Medicine was presented by the Chairman, Dr. W. B. Trites, of Philadelphia. It included the following papers, which were read and referred to the Committee on Publication.

The Effects of Tobacco on the Heart, by E. R. Snader, M.D.

Clinical Cases, by William A. Haman, M.D.

a. A Case of Spinal Meningitis without Rachialgia.

b. A Sulphur Case.

Clinical Cases, by Sarah J. Coe, M.D.

a. Purpura Hæmorrhagica.

b. Unexpected Results from Sizygium in Diabetes.

Chronic Gastric Catarrh, by E. C. Parsons, M.D.

Suggestions Concerning the Treatment of Uncomplicated Cardiac Hypertrophy, by E. R. Snader, M.D.

A Case of Cancer *vs.* Erysipelas and Arsenic, by C. Mohr, M.D.

Unsuccessful Clinical Experience, by Z. T. Miller, M.D.

The Leech and Cup as Aids in the Treatment of Disease, by G. Maxwell Christine, M.D.

A Case of Pulmonary Tuberculosis, by W. J. Martin, M.D.

Homœopathy in the Treatment of Syphilis, by W. B. Trites, M.D.

Staphisagria for the Relief of Mercurial Eczema, by Z. T. Miller, M.D.

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Pulmonary Phthisis, by W. C. Goodno, M.D.
Baby Therapeutics,* by Z. T. Miller, M.D.
Balsam of Copaiva: An Experiment, by E. Cranch, M.D.

THE EFFECTS OF TOBACCO ON THE HEART.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

MEDICAL opinions concerning the effects of tobacco on the heart are by no means definite or uniform, if the various views of writers on the subject be compared. On the one hand, the belief is stanchly held that hypertrophy of the heart is frequently and directly produced by the habitual use of the weed in its various forms. On the other hand, the assertion is made with equal positiveness that no organic heart lesion can be definitely laid to the blame of tobacco. Investigation into the possible effects of tobacco on the heart should, logically, embrace:

First.—An inquiry into the drug properties of tobacco and its active principles, *i.e.*, the power of tobacco to produce toxic effects upon the heart.

Second.—(If the plant shows toxic properties, and they are manifested upon the heart), the nature of that action, *i.e.*, whether sympathetic, specific, or organic or inorganic.

Third.—The signs and symptoms by which we can definitely recognize and systematically classify the tobacco heart disease or diseases.

And, as a natural corollary, from a medical standpoint:

Fourth.—The measures for the prevention, amelioration or cure of the disease.

That tobacco does affect the heart is theoretically certain if the various investigations into the nature of the plant are even

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* This paper was presented to the Bureau of Pædology, but by an oversight, was not included in the report of that bureau, in the early part of this volume. It is, therefore, presented in this place.

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approximately correct. For scientific purposes lay diatribes against the tobacco habit are absolutely valueless, inasmuch as isolated instances are cited as a text for sermonizing, and no effort is made to prove beyond cavil that cited instances of poisoning are unquestionably due to tobacco. Dr. Benjamin Ward Richardson, while studying the effects of tobacco upon the general system, found that there existed in tobacco smoke the following constituents: *Water*, in a state of vapor; free *carbon*, diffused in very minute particles, or soot; some *ammonias* (in a state of vapor), giving to the smoke an alkaline reaction; *carbonic acid* and *carbonic oxide*, each in a state of gas, and a vapor easily condensable into an oily-like substance, like crude *nicotine*. It will be seen that tobacco smoke is a complex substance. The fluid alkaloidal body, nicotine, further yielded a volatile empyreumatic substance, which contained an *ammonia* and a dark, resinous, *bitter extract*.

The products of the combustion of tobacco, however, have been separated into still more refined divisions. Eulenberg and Vohl passed the smoke of tobacco through a strong solution of potassa, and afterwards through a solution of dilute sulphuric acid.

The solution of potassa separated carbonic, acetic, formic, butyric, valeric and other acids, including even hydrocyanic, together with creosote and some hydrocarbons.

"(The acid solution fixed ammonia and a series of oily bases belonging to those homologues of aniline which Dr. T. Anderson first discovered in coal tar.) These bases run parallel with aniline and, under the action of iodide of ethyl, yield ammonium compounds. They are composed of the elements of carbon, hydrogen and nitrogen, and they differ in physical, and, probably, in physiological qualities, according to their atomic weights. The lightest is pyridine, composed chemically of C_5H_5N; the heaviest is viridine, $C_{12}H_{19}N$; and intermediate are picoline, C_7H_7N; lutidine, C_7H_9N; collodine, $C_8H_{11}N$; parvoline, $C_9H_{13}N$; coridine, $C_{10}H_{15}N$; and rubidine, $C_{11}H_{17}N$. Pyridine was found to be most abundant in smoke from tobacco, and picoline, lutidine and collodine in smoke from the cigar." However, in

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everyday smoking, all these products are not formed and inhaled, but the carbon, the ammonia, the carbonic acid and oxide and the nicotine are produced. The carbonic acid and the nicotine are the agents that most affect the heart.

These investigations prove that tobacco has toxic power. The question naturally arises, if toxic, and it affects the heart, through what physiological system are its effects produced? The intensity of the symptoms developed by a first smoke disproves the popular idea that tobacco is a narcotic, like opium. Primarily its action seems to be as an irritant to the motor nervous system, and certainly "not as a narcotic upon the sensational." In addition to the general phenomena produced by a toxic first smoke, the condition of the heart of man, reasoning from the analogy of experiments on animals, ought to closely resemble Richardson's description: "The heart, overburdened with blood, and having little power left for its forcing action, is scarcely contracting, but is feebly trembling, as if, like a conscious thing, it knew equally its own responsibility and its own weakness. It is not a beating, it is a fluttering heart; its mechanism is perfect, but each fibre of it, to its minutest part, is impregnated with a substance which holds it in bondage and will not let it go."

If such are the acute toxic effects of tobacco upon the heart, what are the pathological conditions, disorders and symptoms produced by the abuse of it, and by working in it for a considerable period of time? In a progressive study of the subject, I accepted as a fact the chemical proof of tobacco's toxic power, the probable truth of the asserted condition of the heart in animals when first under the weed's influence, and the reasonable inference therefrom of a similar cardiac condition in man; but, I regarded it as essential that investigation from a clinical standpoint also should positively demonstrate that tobacco produced effects upon the heart. With the end in view of attempting such a demonstration, I began, among the employees of tobacco factories, a series of examinations. The following is a table of the results obtained from the careful examination of thirty-one hearts:

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No.	Sex.	Age.	Time employed working in Tobacco.	Use of Tobacco.		Length of time Tobacco was used.	Pulse Characters.					Pulse Rate.		Character of Impulse.			Palpitation.	Organic Disease Present.
				Chewing.	Smoking		Irregular.	Intermittent.	Weak.	Strong.	Normal.	Standing.	Sitting.	Diminished.	Increased.	Normal.		
			Years.			Years.												
*1	M.	25	24	C.	S.	24				S.		56	68		I.		Yes.	Hypertrophy.
2	M.	29	6		S.	16	I.	I.	W.			136	138	D.			Yes.	
3	M.	23	7		S.	3	I.					76	60			N.	No.	
4	M.	19	6	C.	S.	8	I.	I.		S.		84	80		I.		No.	
5	M.	25	14	C.	S.	20					N.	84	84			N.	No.	
6	M.	25	15	C.	S.	11			W.			80	72	D.			No.	
7	M.	25	12		S.	12	I.			S.		100	80		I.		No.	Hypertrophy.
8	M.	32	22		S.	7					N.	68	68		I.		No.	Aortic stenosis and Hypertrophy.
9	M.	17	7	C.	S.	9	I.					100	72			N.	No.	
10	M.	23	6	C.	S.	10	I.					100	84		I.		No.	Hypertrophy.
11	M.	18	5	C.	S.	8	I.					80	68		I.		No.	Hypertrophy.
12	M.	19	7	C.	S.	9	I.	I.	W.			92	80	D.			No.	
13	M.	22	7	C.	S.	12	I	I.	W.			84	84	D.			No.	
14	M.	18	7	C.	S.	11	I.					72	52			N.	No.	
15	M.	17	5	C.	S.	10					N.	84	63			N.	No.	
16	M.	30	8		S.	20	I.	I.				100	76	D.			No.	
17	M.	22	3	C.	S.	20					N.	72	54			N.	No.	
18	M.	22	7	C.	S.	14	I.		W.			88	76	D.			No.	
19	M.	28	14	C.	S.	21					N.	72	60			N.	No.	
20	M.	22	10		S.	8	I.		W.			104	96	D.			No.	
21	M.	32	18		S.	19				S.		68	68		I.		No.	
22	M.	23	2½		S.	7	I.	I.		S.		88	64		I.		Yes.	
23	M.	21	5	C.	S.	3	I		W.			112	106	D.			Yes.	Hypertrophy.
24	M.	22	6m		S.	9	I.					80	72			N.	No.	
25	M.	21	5		S.	4	I.	I.				96	66	D.			No.	Hypertrophy.
26	M.	23	7		S.	11	I.		W.			72	66		I.		Yes.	Hypertrophy and Aortic stenosis.
27	M.	21	3		S.	11	I.					72	68			N.	No.	
28	M.	26	10	C.	S.	18	I.					92	80			N.	No.	
29	M.	23	9	C.	S.	12			W.			100	84	D.			No.	
30	M.	28	9	C.	S.	13	I.	I.	W.			72	88	D.			No.	
31	M.	29	15		S.	15						64	56	D.			No.	

All the subjects examined were males. The oldest was 32 years of age; the youngest, 17.

The longest period of time employed working in tobacco was 24 years; the shortest, 6 months; one worked 22 years; eight, over 12; twenty-five, 5 years or over.

* This patient was born and raised in a tobacco factory.

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Thirty-one smoked, and of this number fourteen smoked only, and seventeen both chewed and smoked.

The longest period of use of tobacco was 24 years; the shortest, 3; one used the weed 15 years; one, 16; one, 18; one, 19; one, 20; one, 21; and nineteen over 10 years.

The use of the weed was begun in one instance at 1 year of age; one at 5; two at 7; one at 8; one at 10; and the remainder, with two exceptions, formed the habit at or about the period of puberty.

The character of the pulse was irregular in twenty; intermittent in seven; weak in eleven; strong in five (strong in only two cases of hypertrophy); both irregular and intermittent in seven; irregular, intermittent and weak in three; irregular and weak in three; simply weak in two; normal in twelve.

The highest pulse-rate, standing, was 136; sitting, 138. The lowest pulse-rate, standing, was 56; sitting, 56. Eight had a pulse-rate of over 100 when standing; two over 100 while sitting. Twenty-two had a pulse of over 72 while standing; fourteen over 72 while sitting. Three had pulses of less than 70 standing. Three had pulses of the same rate standing as sitting. Two had pulses faster while sitting than standing (one a case of aortic stenosis). The pulse-rate was below 70 both standing and sitting in four cases. In one case of enormous hypertrophy the pulse was 56 standing and 68 sitting. In three the pulse was stronger when sitting than when standing.

The impulse was diminished in twelve; increased in nine (increased in two without hypertrophy); the impulse was (nearly) normal in ten.

Five had experienced attacks of palpitation, three of whom suffered from hypertrophy. Only one had the palpitation directly following the use of tobacco.

Seven cases of hypertrophy were discovered, six simple and two associated with aortic stenosis. It would be manifestly unfair to infer, simply because the subjects of hypertrophy were workers in and users of tobacco, that the enlargement of the heart was due to the plant. All the remaining causative factors of cardiac overgrowth could not be excluded, and hence the solution of the question of origin remains *sub judice*. That the

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tobacco habit can cause the so-called irritable heart I do not doubt; but that tobacco sets up a particular and specific hypertrophic enlargement seems conjectural. It seems only fair to say that the abuse of the plant may lead to an irritable heart, and that an irritable heart may become hypertrophied, but that, if such enlargement does take place as a consequence of the toxic effects of tobacco, it is not a specially peculiar muscular increase, and is probably undistinguishable from other forms. (The existence of the traditional tobacco hypertrophy I cannot but regard as unproven.) In all the cases of hypertrophy I elicited a history of considerable muscular exertion and rough out-door sports. One was a base-ball pitcher. All the hypertrophies were symptomless. In but two could I elicit histories of palpitation, and even this information was secured by dint of close and persistent questioning. The men did not know they had a heart, so far as symptoms were concerned. It is quite possible that the sedative effect, and the cardiac muscular weakness induced by the habit, kept the heart from manifesting its full strength. The effect of the tobacco had probably been to diminish the force of the heart's action and induce vessel relaxation. This symptomless character of the hypertrophy would apparently seem entitled to be considered pathognomonic of the effects of tobacco on the heart, and to be of diagnostic value. However, this symptom is not met with alone in users of the weed. I have seen other symptomless cases of simple hypertrophy where there existed no tobacco habit or history of it.

Neither of the cases of aortic stenosis knew they had heart disease, and but one reported having experienced palpitation. Neither had suffered from inflammatory rheumatism, but one had passed through the exanthemata. In one, the pulse-rate was practically normal, 66 sitting, 72 standing, although in character the pulse was irregular and weak. In the other, the pulse was the same when standing as when sitting. (Equality of the standing and sitting pulse appeared in one other case.) It would be unwise to consider the aortic stenosis due to tobacco simply because of the absence of a history of inflammatory rheumatism. I have seen a number of cases of idiopathic valvular disease. The fact of their symptomless existence is of

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no special significance, inasmuch as compensation was fairly perfect. It is the everyday experience of physicians that valvular lesions are discovered by systematic examinations the existence of which had never been suspected by the patients.

In twenty cases there existed a considerable abnormal disparity between the pulse when sitting and when standing, viz., 56 standing, 68 sitting (hypertrophy); 76 standing, 60 sitting; 100 standing, 80 sitting; 100 standing, 72 sitting; 100 standing, 84 sitting; 72 standing, 52 sitting; 84 standing, 68 sitting; 100 standing, 76 sitting; 72 standing, 54 sitting.

A peculiarity was observed in thirty cases. The power of the impulse seemed to be less than the apparent muscular strength of the heart, and the first sound lacked a proper amount of booming quality. This character is more readily appreciated than explained. I have noticed this peculiarity in other tobacco-users than those whose examinations are tabulated. This alteration was also noticeable in the cases of hypertrophy; that is, the impulse was less strong and booming than would naturally be anticipated from the amount of enlargement. It is not simply the lessened strength due to increased rapidity of action, it is something more than that. The sign appears most explicable by a mechanical illustration: It seems as if a systole capable of exerting a 65-pound force was exercising only 40-pound power, and, associated with this lack of power, even while the heart is acting rapidly, the idea of sluggish movement is conveyed to the ear. The blow of the systole is not well delivered.

Summarizing the apparent effects of tobacco on the heart, we find that the pulse was increased in rapidity (twenty two cases), rendered irregular (twenty), and occasionally intermittent (seven); that no special symptoms accompanied the cardiac changes; that the normal disparity between the pulse, when standing and when sitting, seemed to be abnormally increased; that the impulse seemed to be peculiarly diminished in force, and that the first sound appeared to lack sufficient booming quality for the apparent amount of muscle present.

The toxicity of tobacco ascertained, and the power of the plant to produce cardiac derangement reasonably assured, it is next necessary to inquire into the diagnostic data.

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The diagnosis of the tobacco-heart is by no means easy. As a rule, an irritable heart is discovered, and the dependency of cardiac signs and symptoms upon the use of tobacco, is positively ascertained only by the amelioration following the cessation of the habit. A history of the habit, and of palpitation following speedily upon indulgence, is of signal service. The difficulty in diagnosis arises from the attempt to make out a specific disease entitled to a separate and distinctive place among cardiac maladies. The diagnosis of an irritable heart is, in itself, very easy. All that is needed is rapidity of action, irregularity of rhythm, and occasional palpitation. If the tobacco-heart, and not an irritable heart from the abuse of tobacco, is to be diagnosed, I regard as of especial value the peculiarity noted in the impulse and first sound—a peculiarity, by the way, which I had observed in tobacco-users' hearts before I made any attempt at this special study. Until the investigations reported in this paper, I had never looked for nor noted abnormal disparities between the pulse when sitting and when standing. Hence the value of the observation from a diagnostic standpoint remains to be established or disproved by clinical experience. If the examined heart be hypertrophied, and that hypertrophy gives rise to symptoms insignificant when compared with the amount of enlargement, I believe that the unusual sedation is of value, not in determining that the hypertrophy was caused by tobacco, but that the heart was under the weed's influence.

A few general observations concerning the cases investigated are:

That all those examined began their work in and use of tobacco in adolescence or childhood, a period most likely to develop the ill effects of occupation and of bad habits.

That the chronic toxic effects of tobacco on the heart do not closely resemble the acute effects in animals.

That tobacco increases the action of the heart, and diminishes its force, and that the force is diminished proportionately more than the diminution that physiologically follows increased action.

That irregularity of rhythm is nearly as characteristic as rapidity.

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That intermittency is only of occasional occurrence.

That palpitation is not nearly so frequently caused by tobacco as is professionally and popularly believed.

That there is no indisputable evidence that tobacco causes organic heart-disease *per se*.

That, theoretically, tobacco cannot cause hypertrophy, because, while increasing the rapidity, the muscular power of the heart is diminished.

That, practically, the existence of the traditional tobacco hypertrophy is not proven, all other causative factors not having been excluded.

That there is strong presumptive evidence that tobacco can cause functional disorder of the heart.

That tobacco is one causative factor in irritable heart.

That the tobacco-heart is an irritable heart, *plus* probably a peculiar alteration in the impulse and first sound, a disproportionate disparity between the pulse when sitting and standing, a history of the habit, and *minus* other causative factors.

That it is questionable in the present state of our knowledge, whether it would not be a needless refinement to consider the so-called tobacco-heart as entitled to a distinct classification.

That the cardiac disturbances caused by tobacco can exist without symptoms; and that, therefore, it is not fair to assume that because no symptoms exist no disorder is present.

That the absence of subjective circulatory symptoms is not characteristic alone of the influence of tobacco on the heart.

That the exaggeration of the normal disparity of the pulse when standing and when sitting is worthy of further investigation.

That the peculiarity in the impulse and first sound promises well in a diagnostic point of view.

That conclusions drawn from the investigation of thirty-one cases are simply suggestions of possibilities.

That thirty-one sedentary subjects, not working in tobacco, and not users of the weed, should be examined and the result tabulated in parallel columns with those already investigated, before conclusions should be assumed to possess positive value.

Concerning the therapeutics of the irritable heart we shall have nothing to say at present.

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DISCUSSION.

DR. CHAS. MOHR asked Dr. Snader what the difference between the number of beats in the pulse standing and sitting was in the cases he examined?

DR. SNADER replied that the difference was from 5 to 25.

DR. MOHR said that that difference was greater than is ordinarily found in the healthy. In his examinations of many students for the purpose of selecting subjects for provings, he had made careful notes of the difference in the number of pulse beats, standing and sitting; he had found that the average difference was but 4 or 5, in those who did not use tobacco.

DR. L. B. HAWLEY, of Phœnixville, agreed with Dr. Mohr respecting the normal difference in the number of beats, standing and sitting.

DR. MOHR suggested that Dr. Snader, in his future investigations, make a study of the idiosyncrasies of his subjects.

CLINICAL CASES.

BY W. A. HAMAN, M.D., READING.

a. EPIDEMIC CEREBRO-SPINAL MENINGITIS WITHOUT RACHIALGIA.

THE programme wrongly entitles my paper. Instead of being Spinal Meningitis without Rachialgia, it should be Epidemic Cerebro-Spinal Meningitis without Rachialgia. There is no disease that presents a greater variety of types. We have (a.) the *abortive*, (b.) the *fulminant*, (c.) the *nervous*, including the delirious, cephalalgic, neuralgic, convulsive, paralytic and adynamic (comatose and typhoid); (d.) the *inflammatory*, and (e.) the *intermittent and remittent types*. From the common English and German names, spotted fever and "genickkrampf," the impression is apt to be made that the petechial eruption and painful retraction of the head are invariably present. According to Dr. Stillé, "Nothing can be more irregular, uncertain, or various than the eruptions and other cutaneous symptoms

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that have been met with in this disease."* In an epidemic that was observed by him in the Philadelphia Hospital no eruption whatever was observed in thirty-seven out of ninety-eight cases. Reynolds's Sys. of Med. states that "Rachialgia is rarely absent," and that "the nuchal pain and its consequences constitute one of the most characteristic signs of the disease."† It is a far more constant symptom than the petechial eruption. That "genickkrampf," or cervical rigidity with pain, is not a symptom essential to the diagnosis of epidemic cerebro-spinal meningitis is illustrated by the following case:

Sickness occurring in an eleemosynary institution in Reading, the Home for Friendless Children, has been entrusted to the care of our city Hahnemannian Medical Society. From twenty to twenty-five children are always within its walls, and a physician is appointed every month to attend to such as may need care. February 24th, 1888, 4 P.M., I was summoned to see Nevin Kalbach, a previously healthy boy of 4½ years of age. The preceding night he vomited several times, and during the morning was dull, and preferred lying on the settee. No attention was paid to the vomiting, as it was regarded as the result of eating a hearty supper. At noon he became convulsed without any warning, and, owing to a misunderstanding, was without treatment for three hours. At 3 P.M., Dr. S. R. Rittenhouse prescribed for him. I saw the boy an hour later. The convulsions were not so violent, but were still well marked, and the vomiting, which had recurred with the onset of the convulsions, had ceased; the upper extremities were more involved than the lower; the pupils were dilated to their fullest extent; the teeth were constantly grating, but the tongue had escaped being bitten; I noticed a few brownish erythematous spots on the extremities; pulse was 80; temperature 98.5°. I continued the recipe of Dr. Rittenhouse, and did not commit myself to a diagnosis.

9 P.M. The boy became quiet shortly after I left at 4 P.M. He answered questions correctly, knew me, and expressed his desires. The pupils were not so widely dilated; complete

* Pepper's Sys. of Med., vol. i., p. 816.

† Op. cit., vol. i., 299.

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ptosis was present on the left side; there was no other paralysis, however.

February 25th, 9 A.M. The child passed a restless night. Pulse was 80; temperature 99° Fahr. There had been no recurrence of the convulsions or vomiting; pupils were nearly normal; tongue slightly coated; he had a desire for milk; he did not moan or complain of pain unless he was asked, when he referred to his forehead as the seat of pain; there was no retraction of the head, nor cervical or occipital pain; neither was there any rigidity about the neck, the chin could be made to come in contact with the sternum without any trouble; pressure on the spinous processes of the cervical and dorsal vertebræ was not painful. The spots on the extremities were more marked. I still held my diagnosis in reserve.

9 P.M. The boy was somewhat talkative and knew me. Pulse 80; temperature 99°. Pupils were normal, the ptosis still existing; the grasps of the hands were equal in strength. The rash was very distinctly petechial, did not disappear on pressure; there were frequent alterations in the cutaneous vascularity, both extremes occurring rapidly. The neck was still free from pain and rigidity. Child was restless; he would sleep about five minutes, not longer at a time; he would then awake, sit up, and in a bewildered manner change his position very awkwardly, as though vertigo prevented him from doing so in a natural manner; this scene was repeated regularly, and required the constant presence of a nurse to keep him from falling out of bed. I now gave my diagnosis as epidemic cerebro-spinal meningitis.

February 26th. My patient died at 4 A.M., just forty hours after the commencement of the convulsions, and fifty-two hours after the commencement of his illness. There had been no material change in his condition from the time of my last visit until his death; he spoke five minutes before that event, which was unexpected by his nurses.

Assisted by Dr. D. C. Kline and in the presence of Drs. S. R. Rittenhouse, Marks, and E. Z. Schmucker, I made an autopsy. The petechial eruption noticed before death was plainly visible, and occupied the upper surface of the extremities; its hue was

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quite different from the hypostatic congestion. When I removed the calvarium the intense congestion of all the cerebral vessels was clearly displayed. There was no exudation into the general arachnoidal cavity, neither was there any considerable effusion into the ventricles. At numerous places along the borders of the distended bloodvessels in the pia mater distinct streaks of a fibrino-purulent exudate were quite noticeable; this exudation was upon the sides and upper surfaces of the hemispheres. The base of the brain and that small portion of the cord that I was able to remove through the foramen magnum presented no other evidence of disease than great congestion. Time did not allow me to remove the cord. All the physicians present agreed with me that the result of the autopsy abundantly confirmed the diagnosis of cerebro-spinal meningitis of the fulminant variety. I know that there was at least one other case in the city at that time, and it also resulted fatally. One day after my patient died another inmate, a lad of 5 years, suddenly commenced vomiting, which persisted; this was followed by fever, pain in the throat, head, and neck; although there was no rigidity any attempt to flex the head made him cry; the lower part of his face was blotched with erythematous patches. Belladonna 3x controlled this train of symptoms in a short time. I believe this case of illness to have been aborted cerebro-spinal meningitis.

I did not detail my case under the delusion that it is without a parallel, but because it illustrates several phases of this remarkable disease. This disease has no representative temperature curve. Pepper's Sys. of Med. makes the noteworthy statement that, "Githens has shown that the temperature of the body in this disease is lower than that recorded of any other fever or inflammatory affection; the average, indeed, of his cases was lower by 4 or 5 degrees than that of typhus or typhoid fever, pneumonia, etc."* This statement is not meant to imply that high temperatures are never observed. My case was fatal in a short time, and, although accompanied by purulent meningitis, 99° Fahr. was the highest recorded temperature (it was taken at every visit); the pulse was never more frequent than 80. The

* Op. cit., vol. i., p. 815.

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temperature may have been higher immediately before or after death.

Intense cephalalgia is one of the most characteristic symptoms of epidemic meningitis. The intensity of the headache is peculiar; it is so intolerable as to extort groans and cries from the sufferer even when comatose. Dr. Stillé asserts that, "It is always present, except in those malignant cases in which the morbid poison seems to expend its fatal power upon the blood. In some of a less rapid, but still malignant type, in which after death no exudation is found, but only an extreme venous congestion of the membrane, this symptom may be more or less marked."* The morbid poison in my unfortunate patient did not spend its fatal force upon the blood; as evidence we have the purulent meningeal exudation. From the time of the cessation of the convulsions to within five minutes of his death, he was conscious, except when sleeping, and would give relevant answers to questions, and in all that time made complaint of no unusual headache.

The absence of rachialgia, which is the chief peculiarity of the case, cannot, I think, be accounted for by supposing that there was no inflammatory action affecting the spinal meninges; the great congestion of the vessels in the part of the cord removed with the brain negatives such a supposition. If severe encephalic meningitis can exist without unusual headache, then I would suppose it possible for a spinal meningitis to exist without rachialgia.

Reynolds's Sys. of Med. asserts that, "Rachialgia is not present in the fulminant and in severe cases of the purpuric forms of the affection."†

b. Sulphur, 55 m.

Mrs. R——, aged 28 years, married, and the mother of two children, consulted me about the lobe of her left ear, which, she stated, had been sore during the preceding six months. During this time it had never been healed. She applied salves and

* Pepper's Sys. of Med., vol. i., p. 808.

† Op. cit., vol. i., p. 299.

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ointments innumerable, without any effect, except a very temporary reduction in the swelling, which never lasted more than a day or two. The lobe of the ear was much enlarged, very red, and covered with a cracked scab, from which a gluey, sticky moisture exuded that necessitated a frequent use of the handkerchief. The subjective sensations were excessive itching and pain on contact, which prevented her from resting her head on that side at night. I examined her for traces of the syphilitic diathesis, but failed to find anything to warrant such a conclusion. I prescribed graphites 6x, without any effect. Then sulph. 30, silicea 30, and psorinum 30 were given faithfully, without the slightest benefit. At this stage of the treatment, I lost sight of my patient, as she had become discouraged. During the following eight months I did not get to see her. At the end of that time she returned for medicine for a headache, to which she had been subject since childhood. To my astonishment, I found the lobe of the ear to be in the same condition. It had been in that state fourteen consecutive months. As prescribing for the sore ear had been a failure, I thought that if I were able to find the *similimum* for the headache, it would, at the same time, prove to be the remedy for the ear. She had had headache three or four times a week during the preceding few months; she frequently had the pain several days in succession. The headache was the same in character as it had been when it attended the menstrual periods which it had from their commencement. The pain commenced in the back, between the scapulæ, and spread up the neck, over the occiput and vertex to the frontal region. The pains were accompanied by vertigo and nausea, dimness of vision and sensitiveness to light and noise; pain in the eyeballs on their movement was also present. During the attacks she could not lie down, but had to sit upright in a darkened room, with closed eyelids, and have the head tightly bandaged. Gelsemium corresponded most closely with the headache, but it did her no good. Silicea 30 was then tried, also without effect. When this drug failed, she volunteered the information that she noticed that, whenever her headache came several days in succession, the epidermis on her hands would crack, and be cast off like the scales of a fish. I also learned

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that, in addition to the pain in her head, there was a constant heat, which was also present in her palms and soles, and caused considerable discomfort. I was now positive that it was a sulphur case. I gave it in the 30th, with no effect. I gave her the 200th, with the same result. In despair I turned to my box of high potencies to renew the 200th, when I, by chance, saw a bottle labelled sulphur 55 m. This bottle came into my possession at least 8½ years before, and had been completely forgotten. I gave eighteen powders, and directed her to take three a day. One week after, she returned with the lobe of her ear quite healed and free from pain, and told me that she had the headache but once during the week. I saw her two months later; she was still free from headache, and her ear gave no trouble. Whether this prompt change in the condition of my patient was the result of the administration of sulphur 55 m., or a mere coincidence, no one can positively determine. My belief that sulphur cured the case is supported by the fact that both sore ear and the headache disappeared together.

DISCUSSION.

Dr. John C. Morgan, of Philadelphia, said that, when he practiced in the West, he saw no cases of epidemic cerebrospinal meningitis. The first case he saw, was after he came East. The patient had very characteristic symptoms from the beginning, which are common to many other diseases, as pneumonia. He had flying pains in the head and back, along with the chill. These symptoms indicating a congestive chill, he prescribed camphor, in pills. The attending physician (this was in the army) thought it well, on account of the fever, to add a little nitre. The camphor was, therefore, given along with 20 drops of nitre. This was about eight o'clock at night. At midnight the man was relieved of his severe symptoms. Dr. Morgan said that he regarded camphor as a very important remedy in the early stages of spotted fever. He also referred to the use of alcohol in this disease by the late Dr. David James. He had treated one other case of the disease with cimicifuga, with admirable results.

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DR. W. K. INGERSOLL said that, some years ago, he treated a case of spinal meningitis, in which there was great dilatation of the pupils. The inflammation was confined principally to the dorsal and cervical portions of the spinal cord. The post-mortem examination revealed inflammation of the anterior horns of gray matter. He had treated one case of epidemic cerebro-spinal meningitis with baptisia, with the best results.

CLINICAL CASES.

BY SARAH J. COE, M.D., WILKESBARRE.

JOSH BILLINGS has said: "It's hard to get a good idea of the taste of molasses-candy by letting some other fellow chew it for you."

Cases which have been interesting and instructive to ourselves, where we knew the condition was desperate, and knew the remedy acted savingly, or otherwise, yet reported clinically, seem very simple, because there is so much that cannot be told, so many things that come to a physician by intuition.

In presenting this case of purpura to the Society, it is not to tell what homœopathy has done to cure, but to elicit discussion, and learn if our system of medicine can cure this disease.

PURPURA HÆMORRHAGICA.

CASE I.—Miss K., aged 16, brown hair, blue eyes, robust form, yet under size, had never menstruated, except one little spot upon the napkin, when about two weeks old, which was said by the attending physician to be infantile menstruation.

My first prescriptions for her, about her twelfth year, were for catarrhal sore throat, and general catarrhal condition.

A little later, pruritus vulvæ.

A year later, diphtheritic condition of the throat; the first recorded nose-bleed was immediately following this attack.

From my case-book, in reviewing the family record, I find

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the remedies used were mostly anti-psorics. The several complaints seemed to point to a scrofulous inheritance on the mother's side, and paralysis had claimed several victims on the father's side.

May and June of her fourteenth year, she came to me with headache and dizziness, for which she received pulsatilla, and the faradic battery applied to the abdomen. In October, I find recorded, ringing in the ears.

After this, she received throat and ear treatment by a specialist.

In the spring of her 15th year, she came again for dizzy head. It seemed to point to delayed menstruation as the cause, and pulsatilla or sulphur was given, but most benefit was received from gelsemium.

During the remaining months of the year, she had frequent attacks of ulcerated throat, lasting a few days each.

In January of her 16th year she gave me the first alarming symptom, stiffness of the jaws, for which she received rhus tox. with immediate results.

The year previous her uncle had died of paralysis, so this last-recorded symptom tended to give me a more serious view of the case. During these years, she had been a robust girl, seeming to enjoy life to its fullest extent, aside from the temporary illnesses.

March 15th, she was taken with chill followed by fever commencing at 8 P.M., lasting nearly all night, with morning remission. Not another symptom could be obtained, except bad nose-bleed which was hard to control, bryonia giving most aid.

After two weeks she gave the symptom of pain in the stomach and abdomen, later, spleen and back pains, also marked tinnitus aurium during the fever.

She was not confined to the bed any of this time, rising about 10 A.M., and retiring at 8 P.M. She was exceedingly irritable, making it very difficult to obtain any symptoms, and this manner was exhibited toward all her family.

I had her sent to the mountains for ten days, but the irritability continued. Five weeks from the commencement of her illness, she had her worst attack of nose-bleed. The following day my attention was called to the pain in her toes, and there I saw the

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first purpuric spots. These spots would recede in one place, and reappear in another, with additional ones, mostly on the extremities of fingers or toes.

When the eruption first appeared, the spots mostly had an abrupt, well-defined margin, but as they faded, their outline was gradually lost in the surrounding tissue. The color at first bright red, changed to a violet, deep purple, or blackish tint, then underwent absorption, having the appearance of a bruise. The discoloration was preceded by acute pain in the part, rarely much swelling.

About this time she complained of pain in her hip, which increased until there was a marked shortening of the limb, and seeming impossibility to step on the foot.

Consultation was held, and measurements carefully taken, but no shortening found, and no joint disease.

The heart plainly exhibited anæmic murmurs. There had not been anything to call my attention to heart trouble, except some shortness of breath two years before, but only when running up stairs, or at play. The purpuric spots continued to come and go.

I had her ride every pleasant day, insisting that she must walk to the carriage, and when she recovered the use of the limb sufficiently, sent her to the country where she remained a month, slowly improving, and could she have been induced to remain, would probably be living to-day.

While in the country her fever left her, having continued about nine weeks. After her return, she rode out every pleasant day. As the street before her residence was being excavated for pipes, preparatory to paving, I advised her to go to the mountains again, which she did, but this time with a friend, as companion, her mother being confined at home on account of her eyes.

It was difficult for any one but her mother to control her irritability.

While she was on the mountain, I was called to New York State in consultation, and in my absence, a physician of the other school was called.

She had refused to stay on the mountain, and was home again in the poisonous atmosphere of excavation.

The physician caused her to be put to bed, and there I found

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her on my return. She went down very rapidly under confinement, and, later, he had her removed to the mountain, where she died in less than two months, the heart trouble increasing with great rapidity.

CASE II.—Unexpected results while using syzigium for diabetes.

Mrs. L——, 70 years of age, formerly very stout and robust, applied for treatment, October, 1887, giving the usual symptoms of diabetes, rapid emaciation, great thirst, dryness of cutaneous surfaces, with deep wrinkles and scaly. For six years, had been troubled each winter with naso-pharyngeal catarrh. For twenty years, had carried a wart in the left superior maxillary region.

In the commencement, it was a small papilla, gradually enlarging to the size of a 3-cent piece, and became dark-brown in color. Eighteen years ago, the wart was tied by a travelling doctor. It came off, but soon grew again.

Her father died of cancer of the face, coming late in life.

After analyzing the urine, I gave the patient syzigium.

She returned to me in one month, from her home in Central New York, showing improvement. Syz. 1^x was continued, with the request, that after another month, her son-in-law, who was a homœopathic physician, should carry it up to the 3^x dil., and she continued its use.

In April, she made me a visit, giving a fine report. She had passed the winter without her usual catarrhal trouble. She was more happy over the disappearance of the wart, in February, which came off one morning while at family prayers, not leaving even a scar. Upon inquiry if anything had been applied, she said a few applications of witch hazel was all, but she had prayed that the medicine administered might remove all her ailments.

Her prayer was answered, and gave an unexpected result from syzigium. She had been under strict diabetic regimen. Those who assert that naso-pharyngeal catarrh is caused by reflex influences, as dental disturbances, or irritation of the gastro-intestinal tract, may say, that the strict diet in this case relieved the catarrh.

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Her cutaneous surfaces became smooth, less wrinkled, and a moisture appeared, which she had not known for a long time.

Was this diet or syzigium?

DISCUSSION.

DR. E. M. GRAMM said that he had had several cases of purpura hæmorrhagica, the spots varying in size from that of a pin's point to the size of a turkey's egg. As regards treatment, he confessed that his results had been disappointing; that is to say, after the patient was supposed to be cured, a recurrence of the symptoms took place, and required the patient to seek advice again. He related the case of a child with this affection, and in whose case the result was very disappointing. The child in question was of a thorough calcarea build, doughy, fat, with soft muscles, and very liable to take cold, and in every way an unsatisfactory subject on which to work. He treated that child for three years. The disease would reappear as soon as the little one became in the least run down. Lately, however, she has not had any of these attacks.

The only possible way of curing these cases, is by altering the constitution of the patient, to rid him of the susceptibility to the attacks. While he reported the above case as an unsuccessful one, he had, likewise, had others in which the result was successful. He then described the case of a woman, aged 43, who, on the outer aspect of the right leg, had had a dusky red, desquamating eruption for a number of years, the lesions being from one-fourth to three-fourths of an inch in diameter, with a tendency to coalesce here and there. But, in addition to this eruption, which was diagnosed as eczema cruris, she had another eruption which had existed for about one week before she came under treatment. This consisted of reddish spots which were not elevated, seemed to be deeply situated when they appeared, and the redness was circumscribed in a circular manner, and had a diameter of about one-thirty-second of an inch, increasing slightly during the next twenty-four hours in rare cases. On close examination, a minute spot could be detected in these hæmorrhagic areas, which was the lumen of the follicle in or

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around which the hæmorrhage took place. The appearance of this eruption was preceded by certain rheumatic symptoms. Owing to these, ruta was prescribed, and effected a cure.

The speaker thought that remedies, prescribed for the attacks themselves, would do little or no good. The local application of hamamelis, he thought, to be a mistake.

DR. CHARLES MOHR said, that he had seen but few cases of purpura hæmorrhagica, but these he had treated with entire satisfaction, to the patient and to himself, except in one single case, in which the patient had a number of intermittent attacks for a period of several months, under old school treatment. In that case recovery was never complete. It then passed from his hands, but nothing has been accomplished since. The last case of purpura hæmorrhagica he had treated, was a very marked one. The man was about forty-five years of age, and to judge from his appearance, a workman in one of the mills in the city or vicinity. He was admitted to the Hahnemann Hospital, where the speaker examined him thoroughly. The surface of the body was exquisitely sensitive, and the left leg and left arm were most affected. The spots appeared on both of these extremities to a marked degree, and invaded the hands; there were œdematous swellings about the wrist, ankle and knee-joints. His pains were rheumatic in character. The purplish hue of the eruption, the marked sensitiveness of the surface, the shrinking from the slightest touch, the left side being the most affected, the loss of appetite, the restlessness at night, the failure of vitality which was evidently present,—all pointed to lachesis as the remedy; accordingly, he was given lachesis in the 30th potency, one dose every three hours. In eleven days he left the hospital cured.

DR. J. C. MORGAN, of Philadelphia, said that there were two remedies that ought to be especially thought of in these cases of purpura hæmorrhagica; one of these had just been mentioned by Dr. Mohr; that is lachesis; the other remedy was sulphuric acid.

DR. M. M. WALKER, of Germantown, said that he had used syzigium in a number of cases of diabetes with great success.

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He was, at present, using it in the case of an old lady, seventy-three years of age, who was improving under its use.

DR. W. B. TRITES, of Philadelphia, asked if any provings of syzigium had been made.

DR. CLARENCE BARTLETT, of Philadelphia, said that the only account of the pathogenetic action of syzigium with which he was acquainted was a short note, published in the London *Lancet*, about three years ago. In this it was stated that this remedy had the power of producing glycosuria. Shortly after the announcement of this fact, Dr. W. H. Burt, of Chicago, administered the remedy in diabetes. Allopathists have reported good results from its use in this affection.

CHRONIC GASTRIC CATARRH—A TYPICAL CASE FROM PRACTICE.

BY E. C. PARSONS, M.D., MEADVILLE.

CHRONIC gastritis, or catarrhus ventriculi chronicus, is a chronic inflammation of the mucous lining of the stomach, involving the sub-epithelial connective tissue, and producing, in severe cases, atrophic changes in the glandular structure of the organ.

The ætiology of this disease is not very generally apparent, especially to the minds of those who are suffering from it, as they will usually insist upon no predisposition from hereditary taint, and stoutly urge that their mode of living has been in accordance with strict dietetic rules.

There can be no doubt, however, but that any depraved condition of the blood, hereditary or acquired, such as a scrofulous diathesis, or a syphilitic taint, may furnish the predisposing cause.

An enfeebled condition of the stomach from any cause predisposes to an attack of this disorder, also any obstruction to the circulation from disease of the heart, liver, or lungs.

In the hurry and rush of our American life, the exciting causes of many forms of chronic ailments become increased with each succeeding year.

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With the use of anthracite coal and natural gas for fuel to warm our homes, and the various labor-saving appliances invented and brought to such great perfection by our modern civilization and enlightenment, the average business or professional man scarcely gets physical exercise enough to retain a normal muscular tone, or to divert the blood from his overworked brain, or from his overtaxed and long-suffering stomach.

The telephone and the delivering wagon are made to do duty for the family, the performance of which, but a few years ago, served to increase the muscular development of the boys and girls of the household, and so equalize their circulation as to become no small factor in giving symmetry to the body, agility to the limbs, color to the cheeks, and a vigorous and healthy condition to the various organs of the body.

Systematic exercise is seldom, if ever, continued for any considerable time where increased vigor of body and of mind are the only inspiring motives.

There must be some other incentive, a love, born of a spirit of competition; a desire to excel, or a necessity growing out of physical or temporal wants.

A boy soon tires of batting a ball alone, but how changed becomes the interest when he is engaged in a closely-matched game.

It would be far better for every business and professional man if he would arrange for some physical exercise, of at least one hour's duration in each of the six working days of the week, summer and winter the year round, which should be not only either pleasurable or profitable, but absolutely necessary to be performed at stated intervals.

Besides the exciting causes just indicated, we have many others, such as eating at irregular and at short intervals, eating too rapidly and too much, improper food and insufficient mastication, the habitual use of alcoholic stimulants, the very common use of strong and irritating drugs, and last, but not least, to be here mentioned, the very prevalent custom of resorting to the use of various patent medicines which contain nauseous and irritating drugs and very impure spirits.

Any and all of these are exciting causes, entirely too common

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to be in keeping with our boasted civilization and general knowledge of hygienic principles.

Pathologically considered, we have the initial hyperæmia of the membrane attended by an increased production of mucous and epithelial elements.

Later, the sub-epithelial connective tissue becomes infiltrated with new tissue elements, which are formed into a fibrous structure, causing more or less thickening and induration, with consequent pressure upon the glandular structure, resulting still later in atrophy of the sub-mucous glands.

The post-mortem appearances are not constant. The increased vascularity, which is present during life, may not be apparent after death, owing to the fact that the blood may have passed out of the vessels, in which case we would expect to find the membranes paler than natural.

If fatty degeneration of the glands has taken place, the color of the membrane will be a milky white.

If the disease has been accompanied by any disturbance of the portal circulation, we may find the membrane of a dark slate color, due to a deposit of pigment resulting from hæmorrhages, which have taken place from the minute capillaries within the superficial layers.

The symptoms of this disease are exceedingly variable.

Such patients are usually rather inclined to be solicitous in regard to their condition, and many of them very ready to give in detail the changing experiences through which they have passed.

Individual temperaments, different degrees of severity and different stages of the disease exercise an aggravating or modifying influence, so that, while there are always some characteristic symptoms common to all uncomplicated cases, there is also a very wide range of difference.

The appearance of the matter ejected is quite diagnostic. It is more frequently a tenacious, ropy mucus; but in exceptional cases it may be frothy, and in either case there may be, at times, some admixture of bile.

The effort to vomit is usually attended with much retching, which, not infrequently, proves ineffectual, the fluids only rising

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as far as the pharynx, imparting a very disagreeable crawling sensation in the œsophagus.

Many of these cases, and, perhaps, the larger number, are accompanied with chronic, naso-pharyngeal catarrh, which renders the case not only more distressing, but more difficult to cure.

The diseases with which gastric catarrh is especially liable to be confounded, are cancer and ulceration of the stomach. It may, at least, serve to prevent no little professional embarrassment and chagrin later in the progress of the disease, if an unmistakable differential diagnosis can be made early. Unhappily, however, this is usually difficult, and at times quite impossible.

The pain and soreness in catarrh of the stomach are comparatively slight, diffused, and more or less constant; in ulceration the pains are paroxysmal and the soreness localized; in cancer the pains are radiating at times, spontaneous and paroxysmal, without essential soreness.

Indigestion and vomiting are common to the three diseases under comparison; but the hæmorrhages attending the vomiting are rare and always slight in catarrh, common and profuse in ulceration, and not very abundant but usually of deteriorated blood resembling coffee-grounds in cancer.

Chronic gastritis and gastric ulcer are not confined to any particular age, while cancer of the stomach rarely occurs before middle life. In uncomplicated cases of the two former diseases we find no evidence of any tumor, but cancer of the stomach is attended with more or less induration and enlargement which may elude detection, owing to a possible deep situation near the cardiac orifice. The prognosis in gastric catarrh should always be guarded as the possibility of a cure will depend quite as much upon the physician's controlling influence over the diet and habits of his patient as upon the mild form assumed by the disease, and the care with which remedies are selected and applied.

I wish here to present the history of a very severe and obstinate case of long-standing gastric catarrh, which has been much under my observation, and, at times, under my treatment during the past ten years.

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I was consulted May 3d, 1878, by Mr. M., aged 53 years, short of stature, slightly stooped, and weighing, at this time, about 115 pounds.

Usual vocation, that of a merchant; but, being a gentleman of considerable literary taste, he has devoted much time to reading and study, and but little to physical exercise.

This patient reports having enjoyed good health from childhood until about twenty years ago, when the present stomach-trouble first began, with the following symptoms: slight pain and uneasiness of a dull, aching character, about two hours after a meal, accompanied with water-brash, and followed by vomiting of the contents of the stomach mixed with a ropy or stringy mucus.

These attacks have grown in severity and frequency, so that, for some time previous to the date of this report, they have averaged, perhaps, from three to four a week.

The tongue is only slightly coated, while the appetite is poor. There is but very little desire for any kind of food, but he rather prefers acids, liquids and fruit.

Pulse, 85, and temperature normal. Bowels regular, but slightly constipated, the fæces usually hard and small in quantity.

The urine appears normal, except too highly colored when suffering pain.

Specific gravity of the urine, 1015.

Free from sugar and albumen, but containing an excess of phosphates.

He is troubled with chronic eczema, a dry, scaly eruption about the anus, on the back, and over the flexor muscles of the lower extremities, attended with much itching. Aggravations of the stomach-symptoms are usually attended with evidences of an improved condition of the eczema, and *vice versa.*

When a boy, he had scabies, which was treated with sulphur ointment in the regular way.

He has never been addicted to the use of intoxicating liquors and, prior to the beginning of this trouble, had taken but very little medicine.

Since the attack, he has consulted physicians of both schools in several of the larger cities, with results sometimes quite unsatisfactory, and again almost *nil.*

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He has found, by experience, that smoked meats, veal, cheese, pastry, puddings and custards are not tolerated by his stomach, and are, therefore, avoided; but, like many of these cases, in excluding such recognized indigestible articles of diet, he has also stricken from his bill of fare many others which, if used with a little care and persistence, would, in time, serve to increase the tone of the stomach.

Too many of these cases fail to recognize the necessity of a mixed diet, and seek to restore the normal function of a depraved and weakened digestion by a diet prepared from the cereals alone, which not only do not possess all the elements sufficient for healthy nutrition, but contain so much unchanged starch, or, being prepared from very coarse flour, become sources of irritation rather than elements of nutrition. A more liberal use of milk, with the proteid and fatty ingredients from the animal, would, in many of these cases, aid materially in accomplishing the object sought by careful medication.

To return to the further history of this case, I may say that my first prescription was sulphur 30x, and, at the same time, I insisted upon the careful selection of a mixed diet, such as I have here indicated.

It is needless to say that my dietary injunction was overruled by a too frequent indulgence in ice cream and sponge cake. The sulphur was followed by arsenicum alb. 3x, and this by kali bichromicum 6x, with some apparent benefit for a time, but continuous treatment was abandoned after a few weeks, as he entertained the conviction that a cure could not be effected in his case. I occasionally prescribed for him during severe exacerbations, usually giving temporary relief, and postponing, for a longer interval, a subsequent attack under the influence of such remedies as arsenicum alb., anacardium, chelidonium, graphites, hepar sulphur., hydrastis, kali bichromicum, nux vomica and sulphur.

In January, 1882, his condition seemed greatly aggravated, his suffering more severe, and the vomiting a daily occurrence, notwithstanding the fact that his diet consisted of but one pint of cream each day.

His weight had diminished to 106 pounds, and he was rather despondent and greatly discouraged.

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I advised complete rest for the stomach. A *fast* to be supplemented by rectal alimentation. He consented, and began to abstain from all food by the mouth, after 6 o'clock P.M., January 21st, 1882.

The daily record of his condition during the fast is here given.

January 22d.—Pulse 74, and temperature normal. After cleansing the bowels, began the use of nutrient injections administered by the rectum every three hours during the day, with but one enema at night. Experiences some pain.

January 23d.—Pulse 72, and temperature still normal. He has experienced considerable pain, which he attributes to the injections. Vomited several times.

January 24th.—Pulse 76, and temperature 98° F. Less pain. Slight vomiting in the evening.

January 25th.—Pulse 80, and temperature normal. Feels much better.

January 26th.—Pulse and temperature the same as yesterday; but he has experienced more pain, and there has been some vomiting of mucus.

January 27th.—Condition to-day remains unchanged, except there has been less nausea.

January 28th.—Pulse and temperature remain the same. He has had some pain. Vomited blood and mucus in the evening.

January 29th.—Pulse 76, and temperature 97½° F. He feels weak.

January 30th.—Pulse the same as yesterday, and temperature normal. He is feeling rather better to-day.

January 31st.—Pulse and temperature remain the same. Vomited bloody mucus again in the evening, but not so much as before, and attended with much less pain. Inclined to be despondent and discouraged. Says the enemas cause pain.

February 1st.—Pulse 97, and temperature 98½° F. He has had but very little pain to-day, and rested well last night. There have been two movements of the bowels in the last twenty-four hours. He sat up for a short time, which seemed to rest him very much.

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February 2d.—Pulse 88, and temperature 99° F. The white coating on the tongue is disappearing, and he says that he feels better to-day than at any time since beginning the fast.

February 3d.—Pulse 84, and temperature 98° F. Rested well last night, and feels better to-day than yesterday. Retains the enemas without pain. He is in good spirits, and hopes to get well.

February 4th.—Pulse 80, and temperature 97½° F. Sleep disturbed last night by pain in the stomach, which was relieved by hot fomentations.

February 5th.—Pulse 88, and temperature 98° F. He feels very weak to-day. Weight of body, 92 pounds.

February 6th.—Pulse 80, and temperature 98¼° F. Some pain at 3 o'clock this morning.

February 7th.—Pulse 80, and temperature 98° F. He feels very weak. Used hot fomentations to control the pain.

February 8th.—Pulse 76, and temperature normal. There is extreme weakness. His voice is suppressed and very weak.

Owing to the depressed and weakened condition, discontinued the fast, and began to feed by mouth, exercising the utmost caution by making use of an exclusive fluid diet for some time, and feeding at first a very small quantity every two hours. The enemata, while fasting, consisted of raw eggs and milk, beef essence, mutton broth, and Valentine's extract of beef, the latter of which was borne with the greatest degree of comfort.

During the period of weakness following the fast, the diet consisted, at first, of animal broth from game, mutton and beef, milk and eggs, and, later, Imperial granum, oyster broth, with rolled crackers, etc., until sufficient tone and strength of the stomach was regained to warrant the gradual resumption of a mixed diet.

This required a long time, some two or three months, but was in the end accomplished.

The remedies used during the period of rectal alimentation, were anacardium, arsenicum alb. and sulphur.

From what I have since learned of the experience of others, in the use of lavage as a method of cleansing the stomach, I feel assured that it might have been used with great benefit in this

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case, by aiding materially in relieving the pain experienced, as well as allaying the local irritation and promoting the very satisfactory results otherwise obtained.

It is a simple expedient, promising much in cases of the character here cited, and should be more generally used in connection with complete rest to the stomach.

This paper would be incomplete, without the subsequent history of this case.

On the 21st of January, 1883, Mr. M. called at my office, not for the purpose of medical advice, but rather for the renewal of the friendly relationship existing between us. His step was firm and elastic, his cheeks red with the color of health, and his weight of body about 125 pounds. In fact, he appeared the very picture of health. He said to me, after the usual salutation, "Doctor, did you know this is my anniversary? It is just one year ago, to-day, since I began the fast, and I am at a loss to know whether I should *feast* or *fast*."

He continued well until the following summer, when there were some indications of a return of his former trouble, which have also occurred several times since, but, in each instance, it has yielded readily to treatment.

He now eats heartily of a mixed diet at breakfast and dinner, takes a light supper, and seems to enjoy, at least, an average degree of health.

To summarize, we have, in this case, a few points claiming special interest, such as the long period which had elapsed since the beginning of the disease, a consequent weakened and delicate physique, with a corresponding recuperative power, the manifestly resistant character of the inflammation to the action of medicinal measures alone, and, finally, the very satisfactory effect of *rest* combined with homœopathic medication and the elements essential to nutrition, in restoring the healthy function of an overtaxed and diseased organ.

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SUGGESTIONS CONCERNING THE AUXILIARY TREATMENT OF SIMPLE CARDIAC HYPERTROPHY.

BY E. R. SNADER, M.D., PHILADELPHIA, PA.

THE non-medical treatment of simple hypertrophic enlargement of the heart has received but slight consideration from medical men. "Rest" seems to be the only procedure upon the observance of which great insistence is laid. Careful consideration of the conditions attendant upon hypertrophy of the heart will lead to the conclusion that, in many ways, the symptoms of patients can be markedly alleviated by treatment outside the domain of mere drug-prescribing. Each case of cardiac disease must be considered by itself, and a mode of living laid down for the individual, not on general grounds, but upon conditions and symptoms existing in the patient, which appear to indicate a certain definite line of life that is suitable alone for the person prescribed for.

The paramount indications for treatment are:

1. To preserve nutrition, in order to avoid atheromatous degeneration of the vessels.

2. To remove obstructions to the circulation, in order to prevent further increase in the hypertrophy.

3. To establish a general vessel and systemic compensation against the increased blood and pressure supply, in order to minimize the systemic effects of the hypertrophy and render the economy tolerant of an irremediable evil.

4. To secure cardiac sedation and lessen the force of the systole.

5. To control and ameliorate the symptoms arising from or complicating the hypertrophy, as (*a*) headache, (*b*) palpitation, (*c*) local congestions, (*d*) epistaxis, when frequent and exhausting, (*e*) local flushings, (*f*) mental anxiety, (*g*) pain, (*h*) constipation, (*i*) dyspepsia.

6. To prevent dilatation.

Let us consider some of the means which may be employed to secure these ends.

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Rest and Exercise.

Rest is an important necessity in some cases, particularly when there is beginning dilatation. Rest, however, should not mean—for the majority of cases, at least—absolute repose. So-called passive exercise should be instituted and general massage employed. When the symptoms arising from the hypertrophy are slight, and the patient is decidedly strong, muscularly, his muscular system should be kept up, not by vigorous and violent movements, dumb-bells, Indian-clubs, weights, boxing, running, etc., but by Swedish movements, so-called. The movements just mentioned, upon perfectly physiological principles keep up the strength and nutrition of the muscles. By the slight but definite movements the cardiac muscle is not called upon to exercise the great power necessary to perform severe manual labor or ordinary gymnastics. Occupying, as violent exercise does, a causative relationship to hypertrophy of the heart, the recommendation of exercise may sound strangely. Proper exercise, however, is indicated, and is of value in sustaining the general nutritive status of the patient at the proper point.

The Swedish movements, then, are of service in conserving the general strength, in aiding in the elimination of carbonic acid, in relieving internal congestions, in promoting the appetite, in favoring perspiration, and in quickening all the vegetative processes of the human economy. With a minimum expenditure of force, will-power and nervous energy, regulated movements aid in rapidly eliminating carbonic acid from the muscles exercised, and the rapid taking on of oxygen, fulfilling thus the physiological necessities of muscular nutrition, repair and growth. Violent muscular exertion leads to increased hypertrophy and ultimate dilatation. So-called passive movements tend to sustain the systemic balance against the unusual force exerted by the heart's systole, sustain the general vitality, and tend to prevent atheroma and dilatation from faulty nutrition, render the body throughout more tolerant of the increased blood-pressure, diminish the chances of local vessel break-down by distributing and equalizing the blood-current

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uniformly throughout the bloodvessel system, and minimize the general effects of a local disease-force acting universally.

Where the increased volume and pressure of blood show a tendency to give rise to local symptoms, careful movements in muscles farthest from the seat of the symptoms must be instituted. If throbbing headache, tinnitus aurium and epistaxis be complained of, the movements should be largely confined to the lower extremities. If hot feet, cramps in the legs, etc., give rise to marked discomfort, movements of the arms should be tried. If abdominal symptoms are of most moment, massage of the abdomen and movements of the legs are likely to prove of service. Thoracic symptoms are also to be treated by peripheral muscular movements. In other words, the movements should be derivative. Where exercise of even a mild character gives rise to markedly increased cardiac action or disturbance of rhythm, massage should be practiced.

Baths.

The use of hot or cold water, in proper cases, often gives good results. The care of the skin is of considerable importance. Failure of the superficial emunctories to eliminate waste material leads to peripheral obstruction by mechanically clogging the capillary circulation by pressure. When the skin is inactive, more work is thrown upon the already overworked kidneys, and a clogged skin, taking its aggregate surface into consideration, causes considerable obstruction to the circulation, and the obstruction, peripherically placed as it is, offers its resistance to the heart as a mechanical disadvantage to the cardiac muscle, and tends to produce greater hypertrophy. The skin, then, should be kept clean by repeated bathings.

Water is, however, of further service in the treatment of several marked symptoms of cardiac hypertrophy. Throbbing headache, even if associated with violent symptoms and epistaxis, may be controlled by the immersion of the feet into water hot as can well be borne. The heat and water relax the peripheral vessels, the blood flows more readily where the least resistance is offered, and hence relief is often quickly experienced.

Palpitation is a symptom that, on account of its relation to

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hypertrophy as a cause, is one that must be speedily controlled; for palpitation, frequently repeated, leads to greater hypertrophy. Violent palpitation is sometimes subdued almost magically by a warm bath. The peripheral relaxation of the vessels, induced by the warm bath, seems to calm the irregularly acting heart, by making wider avenues of escape for the blood pumped by the ventricle.

Where the skin of the patient is dry and harsh, and kidney action excessive, frequent warm baths and mild general frictions are indicated.

When the superficial capillaries of the skin are dilated, cold baths are of more service than warm ones. Peripheral enlargement of vessels certainly slows the blood-current, and is more or less obstructive.

Food and Beverages.

The diet of each case should be regulated, not captiously, but by ascertaining the idiosyncrasies characteristic of the patient. As a rule, all the articles of food which agree should be used. Food, condiments or beverages which give rise to palpitation, should be rigorously excluded. In general, the diet should be easily assimilable and largely albuminoid, particularly if there exists a tendency to excessive fat formation. Foods that produce flatulence should be forbidden. Table waters containing carbonic acid are contraindicated. The gas liberated is likely to give rise to pressure against the diaphragm and induce palpitation. If the patient be anæmic and dilatation threatens, predigested foods should be employed, rest from active exercise enjoined, and slight universal massage recommended. If the patient is elderly, and not especially nervous, is inclined to fatty degenerations, and the urine shows evidence of rapid tissue disintegration, coffee with cream is of service. However, if coffee causes palpitation its use must be eschewed. Spirits, inasmuch as they stimulate the heart, are absolutely forbidden, except in those few extremely rare cases, where it is found that small quantities of alcohol assist digestion. Malts are objectionable on account of their tendency to unhealthily fatten, and produce fatty deposits, if not fatty degeneration.

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Water is of service as a laxative. Constipation, on no account should be permitted to exist, especially in atheromatous patients in whom, in addition to the evil of imperfect elimination of waste material, there exists the danger of vessel-rupture from the straining efforts at stool. If not abnormally rapid, quick retrograde metamorphosis and elimination favors ready assimilation and general nutrition. Therefore, all the excretive functions should be easily performed, and without special strain. Water, taken before retiring at night, and in the morning before breakfast, together with a regularly established time for moving the bowels, will frequently act as a laxative. Water, drank in the manner and for the purpose recommended, must be used, in some cases, for some time before the habit of easy and regular bowel movement is definitely established. Strong insistence on the part of the physician must be brought to bear to secure observance of the rule. Patients are prone to be impatient at the slow results of the "water cure." When obtained, however, the results are greatly superior to those brought about by the continual use of more powerful laxatives. Water used in the manner described has the additional advantage of flushing the kidneys and stomach.

Milk, on account of its nutritive value, is of use where solid foods are not well handled by the stomach, or when there is threatening or actual cardiac dilatation. The bilious-producing and constipating effects of milk complained of by some patients, are frequently overcome by the addition to the milk of a pinch of salt.

Miscellaneous.

Pains in the chest are occasionally found to be relieved by the application of hot, dry cloths over the painful area.

Cold extremities are relieved by general movements and massage. When the heart's action is very powerful, and hot feet and hot head are the principal symptoms complained of, and there exists neither irregularity nor intermittency sufficient to grossly disturb cardiac rhythm, the smoking of a cigar will greatly diminish the force of the systole and ameliorate the symptoms. Observation of the hearts of a number of smokers leads me to the conclusion that smoking diminishes the force of the systole; that is to say, the force of the impulse was dispropor-

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tionately weak for the amount of muscle and power. Some of the smokers complained of cold feet, which I believe to be due simply to the fact that the heart, with its diminished systolic force, failed to force sufficient blood to the extremities to keep up the temperature. I recommend smoking, therefore, in selected cases. The smoking habit, when indulged in therapeutically, frequently accomplishes cardiac sedation and consequent relief of symptoms very rapidly. When smoking gives rise to palpitation or causes grave irregularity of heart-action, its use should be absolutely forbidden.

The necessity for fresh open air in cases of hypertrophy, in order to secure perfect and rapid blood oxygenation, is so obvious, that I shall not attempt its discussion.

Let me briefly recapitulate the indications for treatment:

To preserve nutrition.—Slight movements, derivative or general as indicated; aid elimination; feed nutritiously.

To remove obstructions to the circulation.—Keep the skin active and clean; remove local congestions by derivative movements and appropriate baths.

To establish a general vessel and systemic compensation against the increased blood-pressure and supply.—Sustain the balance of the economy against the increased force by regulated exercise that shall tend to bring up the muscular system to its highest point without inducing further hypertrophy, and so assist in forming a resistance to the systolic force; by the removal of all removable obstructions; by sustaining general nutrition at its maximum status at the minimum expenditure of heart force; by speedily ameliorating local congestions; by derivative movements and baths.

To accomplish cardiac sedation and lessen the force of the heart's systole.—By preventing palpitation; by diet; by the removal of circulatory obstructions, and by the use of tobacco.

To control and ameliorate the symptoms arising from or complicating the hypertrophy. Headache.—By hot baths, slight derivative movements, smoking, and the erect posture.

Palpitation.—By hot general or local baths; regulating the bowels by diaphragmatic movements, water-drinking, by dieting.

Local congestions.—By baths, hot or cold, general or local, as indicated, and derivative movements.

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Epistaxis.—By warm foot-baths, cold to the nostrils and occiput, massage of the liver and derivative movements.

Local flushings.—Derivative movements and warm baths and local cold bathings.

Mental anxiety.—By assurances of safety and by giving the patient something to do; making slight movements and affording immediate relief of palpitation, etc.

Pain.—By dry heat, relief of pressure, derivative movements.

Constipation.—By water-drinking, by abdominal massage and by daily self-instituted diaphragmatic contractions.

Dyspepsia.—By regulated diet, general massage, tonic cold baths, local epigastric rubbings, and lavage of the stomach.

Tinnitus aurium.—By derivative movements and hot foot-baths.

To prevent dilatation.—By sustaining general and local nutrition; by giving the heart-muscle light work by employing slight motions in order to stimulate nutrition, the avoidance of excitement, hard work and sudden movements, liberal diet and coffee in the degenerate.

While treatment of the symptoms of hypertrophy with drugs, in my hands, has been quite successful, it is beyond the province of this paper to mention the remedies that have proven useful. My object has been simply to suggest the importance of auxiliary treatment in simple cardiac hypertrophy, and to put a few more weapons into the armamentarium of the physician with which to combat the symptoms of this disease.

A CASE OF CARCINOMA OF THE BREAST VS. ERYSIPELAS AND ARSENIC.

BY CHARLES MOHR, M.D., PHILADELPHIA, PA.

THIS interesting case occurring in my own practice, I relate on account of its rarity and suggestiveness.

On July 23d, 1886, I was consulted by Mrs. E. M. H——, a widow, æt. 83, about a lump she had noticed for an indefinite time in the left mamma. Occasionally she had suffered some

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pain, at infrequent intervals, but latterly the pain recurred oftener and was more persistent. Except the lump and pains, and a vertigo, experienced most after first lying down, and when rising from a sitting posture, or when turning the head suddenly, her health was good, and she was a woman who had reared a family, had been very active, and scarcely ever employed a physician.

An examination of the breast revealed a somewhat flattened tumor almost centrally located, about the size of a hen's egg, hard and inelastic, and presenting irregularities. The tumor was adherent to the skin, there was slight dimpling, and fixation of the nipple, which I could not draw forward. I could not detect any glandular involvement in the adjacent lymphatics and despite her age, because her general health was good, I advised the extirpation of the growth. The patient and her family objected to any operative measures, and I was asked to treat the case purely medicinally. I, therefore, prescribed *conium*, IX, a drop mixed in twelve teaspoonfuls of water, and given in two teaspoonful doses every three hours for one week. Improvement in the vertigo was soon manifest and the mammary pains were less severe at the end of a week. I then stopped medication, but repeated my prescription of *conium*, IX, on August 4th and 17th, 1886, and on January 1st and May 27th, 1887, always with the relief of the pains and the vertigo. The tumor, however, continued to grow. Retraction of the nipple ensued, the adhesion to the skin became more marked, and the vascular channels were occluded, as indicated by discoloration of the skin and enlarged veins. On July 23d, 1887, an examination showed a still greater area of infiltration, with involvement of the axillary glands, and in the neighborhood of the original growth small but firm indurations were felt and seen. The neoplasm was now easily recognized as a large projecting tuber elevating the skin. At this time she suffered from intense pains, shooting and lancinating in character, going and coming quite unexpectedly, and robbing her of rest and sleep. *Belladonna*, I, in drop doses, on sugar of milk, was then administered, and I had the satisfaction of again witnessing relief. From this time until October 15th, 1887, she required no other

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medicine, at least I gave her none, although ulceration of the skin had taken place, and the fissure had gradually widened and deepened, until a shallow excavation, with indurated edges and a ragged base, was anything but a sightly object. As she had suffered but little pain, lost little sleep, and was fairly active for so old a woman, I preferred to resort to earth dressing to absorb the thin, ichorous and offensive discharge from the ulcer, and to keep up her strength as well as possible by systematic and careful feeding. A few doses of *lachesis* 30, were given on October 15th, because latterly when she experienced pain it was always after sleep. The patient, however, grew more and more feeble, lost appetite, was compelled to seek her bed, from which it was supposed she would never arise, and towards the latter part of November, 1887, general infection was pronounced; there were present all the phenomena of a cancer cachexia. This state continued until December 19th, 1887, when I was summoned to witness the patient extremely restless, complaining of chilliness and much fever, frequently demanding water, of which she would only take a sip or two, and complaining of most severe burning pain in her breast, the worst she had ever experienced. The symptoms had set in after midnight and, continued to grow in severity, attended by delirium, until 8 A.M., when I reached her bedside. An examination of the breast at this time revealed a complete dryness of the ulcerated excavation, and a distinct line of redness extending outward from the edge of the ulcer about an inch, with a sharp outer border. Not only was the axilla filled with enlarged and indurated lymphatics at this time, but the supra-clavicular glands were prominent in the now emaciated patient. The tongue was dry and the pulse accelerated, the temperature variable, and the patient's face expressing great anxiety. I could do no better than prescribe *arsenicum*, 3x, trit., of which she received one grain every two hours. If there was any question of diagnosis as to the sudden inflammatory symptoms on the morning of December 19th, there was none on the following day, for the inflammation of the skin had spread rapidly, extending upwards to the neck and downwards to near the crest of the ilium. The inflamed portion of the skin was somewhat raised, with a sharply defined irregular border intensely red, hard to the touch,

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but pitting slightly on pressure from displacement of serous infiltration beneath. It was undoubtedly erysipelas. Under the *arsenicum* the febrile symptoms abated, the severe burning became less, sleep was induced, and while the thirst lessened, the appetite, which had entirely disappeared, improved. I next noticed a rapid disappearance of the enlarged lymphatics of the supra-clavicular and axillary regions, and within ten days they were scarcely perceptible. Then the cancerous mass itself began to grow smaller; the ulcerated excavation became more and more dry and less offensive, and on January 22d, 1888 nothing remained of the neoplasm but a puckered cicatrix about two inches long and one-half inch wide. In the meantime the general health improved marvellously, too; the appetite became excellent, food was readily digested and assimilated, she fleshed up, slept well, and suffered very little discomfort in any way. Indeed, so thoroughly restored was she, that, despite a fracture of the left humerus, induced by a fall while getting out of bed on the morning of April 5th, 1888, repair, under surgical treatment, was rapid, and on April 29th it was possible to remove all dressings and to begin motion at the shoulder and elbow joints. At the present time she has complete use of the arm, is in good flesh, goes about the house as freely as her impaired vision from senile cataract will permit, and for one in her eighty-sixth year is in a fairly good condition.

There are some interesting points about the case I will summarize:

1st. The unusual age of the patient when the growth was first noticed.

2d. The relief of pain and other subjective symptoms by the selected remedies, viz., *conium*, *belladonna* and *lachesis*.

3d. The rapid disappearance of all the signs of a malignant growth (except the cicatrix) and the attendant cachexia on the supervention of erysipelas.

4th. The marked amelioration of the symptoms of the erysipelas from the *arsenicum*.

5th. The rapid repair of a fractured arm, occurring so late in life and so soon after the disappearance of the neoplasm.

I am not quite satisfied that the erysipelas alone cured the cancer; the *arsenicum* may have had something to do with the

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result. That the disease was a carcinoma I have not the least doubt, although I must admit that no microscopic examination of the tissues had been made at any time; but the history of the growth and the macroscopic appearances were so marked in favor of carcinoma, that I deemed the microscopic test unnecessary; and with my diagnosis two experts agreed. Will there be a recurrence? Time alone can tell, and I shall watch the case with interest. And now for an important question: In the light of this case, would one be justified in inoculating a patient suffering from cancer, where operative measures were contraindicated, with the virus of erysipelas, to bring about a possible obliteration of the neoplasm?

UNSUCCESSFUL CLINICAL EXPERIENCE.

BY Z. T. MILLER, M.D., PITTSBURGH.

The music for this paper should be funereal. The cases all died.

If you do not give me credit for the results and methods of this practice, you will, at least, accord me a degree of courage for presenting cases that were unsuccessful.

Success stops the mouth of every one, no matter how questionable the means by which it is obtained, but the *lack* of success starts us bristling with eagerness, to suggest better ways. These cases and comments are reported, to give you an opportunity to bristle.

Child, 6 months. July 10th.

1. *Marbled skin.*
2. *Eyelids swollen* and *red*, mornings. Nose dry.
3. *Tongue* coated *white.*
4. *Vomits* after *nursing;* not all the time.
5. *Skin yellow*, dirty looking.
6. Stools green, slimy, containing curds; offensive.
7. Chewing motion of mouth.
8. Sleeps, eyes half open.
9. *Hair dry.* ℞. *Sulf.* 30

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Sulf. was given on account of symptoms 1, 2, 5 and 9. Twenty-four hours passed, and the following:

1. Head hot all day.
2. Gagging a great deal. Vomited once.
3. Three stools of yellow and dark stuff.
4. Chews all the time.
5. Eyes mattery in morning.
6. Draws eyebrows, as if pained in the head.

This looks like *helleb.*, especially the second, fourth and sixth symptoms, but, thinking that sulf. should have more of a chance, followed it with *sac lac.*

July 12*th.*

1. Temperature, 102¾°.
2. Head very hot. Hands and feet cold.
3. Green, slimy stools, containing curds.
4. Constant crying, as if in pain.
5. Wakes up with starts.
6. Nose very dry inside.
7. Eyes heavy.
8. Face yellow.
9. Tongue not coated much.
10. Rolls eyes up into the head.
11. Urine stains diaper yellow. ℞. *Bell.* 30.

The first six symptoms led to the selection.

July 13*th.* 11 A.M.

1. Temperature 99¾° (three points less than yesterday).
2. Whines pitifully while awake.
3. Head *not* so hot.
4. Green, slimy stools, containing curds.
5. Stuffs both hands into the mouth, as soon as wakes up.
6. Nose still dry.
7. Does not roll the eyes so much.

Considering the decrease of temperature, less heat in the head, I gave sac. lac. with one dose *bell.* 30, to be given in the evening, if not better.

July 14*th.* 11.20 A.M.

1. Two green, slimy stools.
2. Coughs short, hacking. Cries.

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3. Eyes red and mattery.
4. Nose very dry.
5. No thirst.
6. Labored breathing.
7. Tongue dry and smooth on tip. Coated back.
8. Temperature 102½°, a rise of nearly three points.
9. Sleeps well at night.

Noticing the marked amelioration of the fever under bell. 30, and the increase of same on discontinuance, I decided to give it again, every three hours, in water.

July 15th.

1. Stools not so green or slimy.
2. Coughs the same.
3. Eyes mattery and sunken.
4. Temperature, 101½°.
5. Sleeps in spells.
6. Face pale.
7. Head hot again.
8. Seems better in the evenings.
9. Gagged this morning.
10. Still cries pitifully. ℞. *Kreos.* 6.

Symptoms 9 and 10 led to this selection. The crying, not an angry cry, and the gagging or vomiting, from probable cerebral irritation, has frequently been relieved by it.

July 16th.

1. Did not rest so well. Cried nearly all night.
2. Two stools. One yellow; other, light, yellow-greenish mucus.
3. Vomited three or four times. Threw up after each powder which was given dry.
4. Tongue not so dry.

Sac. lac. one powder, kreos. 6, night. I hardly believed this an aggravation of kreos., but determined to continue the influence.

July 17th.

1. Temperature, 100°.
2. Slept better.

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3. Six stools; green, slimy, blubbering; no pain; flatulence. Abdomen excavated. Skin wrinkled.

4. Still cries.

5. Head not so hot.

6. White-coated tongue; tip dry, brown red; edges red.

7. Slight cough. Kreos. 6.

July 18th.

1. Child now much emaciated.

2. Cried all night.

3. Six stools, yellowish green.

4. Temperature and pulse normal.

5. Still cries.

6. Sleepy, but cannot sleep.

7. Rubbing nose. ℞. *Calc. ph.* 6.

Calc. ph. was given on general principles. The general appearance of the child, the stools, emaciation, etc., leading to the choice.

July 19th.

1. Very restless during the night.

2. Five stools, not so green, darker yellow.

3. No fever. Pulse normal.

4. Vomited several times during the night.

5. Sleepy, but cannot sleep. ℞. *Sac. lac.*

From July 19th, there seemed an abatement of all the symptoms. I did not see the child for ten days.

July 29th. Child brought to the office.

1. Child's head very hot again.

2. Gags after nursing.

3. Does not whine and fret so.

4. Stools dark yellow; three per day; watery. ℞. *Podo.* 200.

Symptoms 1, 2 and 4 led me to *Podo.*

July 30th.

1. Three stools, with some slime. Other times, nothing but water.

2. Gags after nursing. Vomited four times during night. Vomits milk as eaten.

3. Head hot as ever. ℞. *Podo.* 45.

August 1st.

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1. Four, yellow, slimy stools.
2. Head not hot any more.
3. Vomits the milk as soon as nurses.
4. Drowsy, but cannot sleep. One dose Podo. 100.

Child again improved, so that I did not see it again for eight days.

August 8th.

1. Vomits after nursing.
2. No diarrhœa.
3, Gagging cough.
4. Still growing thinner. ℞. *Fer. ph.* 3.

August 10th.

1. Vomiting much worse. ℞. *Fer. ph.* 200.

August 11th.

1. Sleeps during night.
2. Vomits curdled milk.
3. Quiet only when carried. ℞. *Cham.* 200.

Three days later,

August 14th.

1. Child not so fretful.
2. Stools were yellow, but now green slimy and offensive.
3. Head cool.
4. Thirst. ℞. Cham. 94, one dose.

August 15th.

1. Vomited all night. A dark, coffee-colored water. No smell.
2. Growing much weaker.
3. Yellow stools.
4. Rolls head. ℞. *Helleb.* 100.

August 16th.

1. Arms purple to elbows.
2. Vomits everything, Same color.
3. Great anguish and restlessness. ℞. *Ars.* 200.

August 17th. Symptoms all worse. The coffee-colored vomiting continued. Generally purple stools of blood. Exhaustion. Cold, but would not be covered. Eyes crossed. ℞. *Secale* 3. Died to-day.

This child was sick about forty days. It had many remedies, too many. Twice during the illness, a recovery was confidently

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expected, many symptoms disappearing. My diagnosis was entero-colitis, developing a tubercular meningitis. The constant whining, the progressive emaciation, the fluctuations of fever, with no marked improvement otherwise, the frequent stools pointed to entero-colitis. The chewing mouth, constant whining, dry nostrils, rolling eyes, excavated abdomen, to meningitis. There was no paralysis of one side of body.

The treatment did not cure it. Old-school statistics, twenty-three out of twenty-five died. That it could have had better treatment, I am confident. What is it?

Another child, fair, light hair, twelve months, had diarrhœa for two months.

August 28th. Early, I found it vomiting the water and food it took. Watery, curdy diarrhœa; painful. Thirst for water, which it took greedily, and in small sips. The skin was cool, the anguish and restlessness very marked. The child screamed with pain, at stool. *Arsen.* 200 was given, and the vomiting and diarrhœa were checked, but about 7 P.M., while the child was apparently sleeping, it went into convulsions, with intense fever (4½), in which it continued until death ensued. At 7.30 I gave *cup. ars.* 6, determined to call soon, but found the child dead on my return. Was *ars.* not the remedy?

Another child, six months, fair, light hair, and fat. In the early evening, August 6th, it nursed. Suddenly it cramped up, grew pale, vomited curds. Cold as ice, then slept. When I saw it, it was sleeping quietly. Skin cool; respirations normal. *Camph.* IX.

Following day, August 7th, reaction had set in. Skin hot and dry. Stools of pure blood. ℞. *Fer. phos.* 200.

August 8th. The child was in convulsions at 8 A.M. Skin very hot, belly bloated. *Mag. ph.* 6. At 10 A.M. it came out of the spasm; recognized; nursed. At 5 P.M., temperature 103½°. Stool bloody. *Died.*

That was the second case of the kind I had seen. Both died.

Would any other treatment have saved this child?

July 27th. Another child, eleven weeks old. Long, slender, purpural spots all over. Always worse during a thunderstorm. Mother had hæmorrhages from lungs during third

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month of pregnancy. Stools inclined to be yellow. Ravenous, but vomits after it eats. One dose phos. 200 was laid on the child's tongue.

July 29th. It was brought back to the office. One more large purple spot had appeared on the abdomen. Child was very feverish, but does not vomit so much. Bowels seem swollen. Mouth clean. Very touchy; if a fly lights on her, she screams. One dose *phos.* 100. Died next day. This child had been sick some time. Physicians declined to treat it, but the opportunity to test *phos.* for the above symptoms, led me to prescribe it.

SOME GENERAL REMARKS ON BLOOD-LETTING.

BY G. MAXWELL CHRISTINE, A.M., M.D., PHILADELPHIA, PA.

I KNOW upon what tender ground I am treading, in a reference, before a homœopathic society, to blood-letting, despised and rejected, as it has been, by the greater number of homœopathists, from the time of Hahnemann down to the present day. I am, likewise, aware that the discussion of such a subject, in this place, and under these circumstances, will be viewed by some as being without the domain of a homœopathist's study, and, therefore, an unwarranted innovation; and, by others, as an unearthing of a mode of treatment, long ago buried beneath the notice of a follower of Hahnemann; but I hope it will be regarded by, at least, a few, and finally by all, as in consonance with the trust which our office, as physicians, imposes upon us.

The misgivings, in the choice of this subject, have been dispelled by the contemplation of the spirit, quietly but effectually at work in our midst, toward effecting a harmony of action between the operation of Hahnemann's law and the use of palliatives, so-called. Furthermore, the presentation of this paper has sufficient justification in the expressed thoughts of valued contributors to our literature, if that were necessary; for, from the pen of Neidhard, Goodno and Pitcairn, we have, respectively, the following:

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Hahnemann's law of cure "does not deny the necessity of *occasional palliative means*,*, when the true simile is not found, or when a cure, according to the nature of the case is impossible."

"One may believe what he will, concerning the infallibility of remedies prescribed according to Hahnemann's law, the bald fact, that we do not cure all our cases which, seemingly, ought to be cured, stares us in the face. . . . . *The practitioner, who does less* (than to use drugs physiologically prescribed to tide over the patient until such time as we can prescribe more successfully), *is unworthy of the name physician.*"

"We must familiarize ourselves with and investigate all things pertaining to therapeutic science, holding fast to that which is good. . . . . One of the elements that contributed to the phenomenal success of homœopathic practitioners in the past, was that, while believing firmly in the fundamental principles enunciated by Hahnemann, they were yet broad-minded investigators of the truth from every source and all the schools, recognizing the ever-widening, expanding, increasing range of discovery and improvement."

Quotations of this kind could be numerously multiplied, each furnishing good reason for the occasional, or even frequent, stepping aside from a reliance upon the homœopathic law to the adoption of some other, designed to reach a result which, in its attainment, might be far from homœopathic, but which, nevertheless, would not be, in any wise, destructive of, or damaging to, the truth of the law of similars. The true and the safest conception of homœopathy is that "the law of *similia similibus curantur*, is the *chief*, though not the only, foundation for therapeutics." † And I would ask, whether, simply because blood-letting is not treating disease by the homœopathic law, we should reject it as unworthy our attention? And yet, many do so, without having given the subject even a momentary thought, preferring, in their devotion and zeal to homœopathy, to struggle against disease "on that line, even if failure is the result." Is the fidelity to a principle, which means the erection of a wall between the castle in which it sits enthroned and the

* Italics by the author of this paper.

† Kidd.

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practice of life, necessary or even wise? I think that those who are broad and liberal-minded, will answer with me, no, to this question, and will see in the resort to blood-letting or any other similar measure, no lack of faith or belief in homœopathy; nor in my treatment of the subject before a homœopathic audience, a questionable or deficient veneration for Hahnemann and his system.

I believe that we fail in our manifest duty, if we reject the assistance blood-letting affords in the treatment of certain inflammatory affections. More than this, I believe that he who so rejects it, is guilty of a violation of a deep and certain obligation we owe our patients, to leave nothing undone that will ameliorate suffering, cut short disease, and prolong life.

In the days of long ago, when the blood-letter's vocation was chief to that of the physician, when copious bleeding from the arm was the first thing done in every disease, without reference to indication or contraindication, and when Darwin's theory of the "survival of the fittest" (or the strongest) held dominant sway, it was the natural result that reaction should ensue, and that that which, in certain instances, was invaluable, should now be so completely abandoned that few would dare again to advocate it.

In company with this exile, went the emetics and purgatives that, for a long time, were so destructive to human life. But, in that period these agencies were employed indiscriminately, and fortunate was the poor sufferer who survived his bleeding, emesis and purgation. Yet emesis and purgation have their uses. Misuse does not militate against the proper use of a means; it simply calls for care and discretion in the use. This is an age of scientific investigation. Disease is closely studied, and every phase of it is watched and noted. Medicinal and other remedial agents are not administered haphazard, but their effects on health and disease are made the subject of deep and prolonged inquiry. The physician intelligently watches disease, and applies his remedy, and does not work, as formerly, with both disease and remedy shrouded in darkness. The art of blood-letting has felt the impress of this change, and to-day it is the sheet-anchor of hope in cases, otherwise doomed. Its reckless misuse in

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former times has been succeeded by the establishment of definite rules, whereby good, and not evil, may be consequent upon its employment.

But, says some one, "Consistency is a jewel, and how can a homœopathist, true to his colors, employ blood-letting, and yet be consistent?" I see no reason why the homœopathist cannot consistently employ blood-letting with as much freedom, so far as consistency is concerned, as he would use purgatives or enemata, with which to unload a rectum overfilled and inactive, or an emetic to eject from the stomach an offending poison or food-mass, or a trocar to relieve an ascites. These are measures not to be set aside, and their use by the homœopathist is, in nowise, a sign of disloyalty. No more so is a resort to blood-letting. Purgation, emesis, blood-letting, etc., when rightly used, are handmaids to our treatment of disease, and, because we are homœopathists, renders this statement none the less one of fact.

In recommending bleeding, whether by lance, cup or leech, for certain inflammatory conditions, I do not lose sight of the statement of many, that there is no need for it, inasmuch as homœopathy has the condition which blood-letting is designed to control, completely under the management of its drug-remedies. In my experience, and as far as I have been able to learn from the practice of others, the statement that homœopathy is sufficient in all instances of disease, is without stable support. I cannot conceive of a drug-remedy, under any theory or by any mode of administration, doing the work really designed of blood-letting, and this is said with a just estimate of the power drug-action asserts over the circulatory system, and hence over inflammation. This is illustrated in the relief afforded, and the cure effected by the cupper, in cases which, before application to him for the exercise of his art, have in vain exhausted the skill of the physician's medicinal treatment. I have had enough instances of this kind to come under my notice, to free this statement from possible over-coloring. Some of them have been cases coming from the care of practitioners in our own school—men, undoubtedly skilled in homœopathic treatment. Medication was futile; it was the cupper's art that was needed.

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Now, if homœopathy, with all its brilliant array of victories won over inflammatory conditions, will but take unto itself this measure, study it with respect to its relation with drug-remedies, note where the one is indicated and the other contraindicated; and where the one ends and the other begins, our school will but strengthen itself, and be able to present a more solid and invincible front to the dread feller—Disease.

With this somewhat long, and yet not unnecessary premise, let me pass to the consideration of inflammation, and its treatment, in certain of its phases, by blood-letting.

INFLAMMATION.

Inflammation as defined by Wyeth is a "condition of animal tissues which are undergoing certain disturbances in nutrition which produce hyperæmia, heat, redness, swelling and pain." But as described by Wagner, "the essential phenomena of acute inflammation is the congestive hyperæmia of the vessels, exudation of serum and fibrin, and the exit of red but especially colorless blood corpuscles, which latter form the pus corpuscles." In every case of inflammation there is a certain course, beginning with the irritation—the manifestation of the cause—and passing through contraction of the vessels, dilation of the vessels, acceleration of the current and hyperæmia, retardation of the current, redness, swelling, heat, pain, escape of vessel contents, on to cicatrization. In ordinary inflammations like that resulting from the scratch of a non-infected needle, these phenomena are so mild in character as to pass from one to another without much discomfort, and with no effect but a local one. But in an inflammation of a more serious type, such as that of pneumonia, the various stages occur in a very acute form, and the effect is general as well as local. In the needle scratch, the inflammation is mild, and nature may be allowed to work out a recovery. But in higher grades of inflammation, where organs are implicated and life is in jeopardy, the various phenomena assume serious conditions, and the art of the physician is necessary to be added to the forces of nature, in order to effect a cure, or curtail the disease. Now, as we watch a typical inflammation, and none better is furnished than a simple acute

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pneumonia, we first become impressed with the necessity for relieving the congestive hyperæmia, which is responsible for the redness, swelling, heat and pain. If much time has elapsed from the initial irritation, and the stage has been reached where an escape of the vessel contents has begun, the period has mostly gone by when treatment directed to the hyperæmia, and its direct results, is fruitless. But early in the course, before the congestion is most active, and the fire of the fever is fiercest, much, very much, can be done toward lessening the suffering and shortening the process. The pharmacopœia is full of medicines designed for this purpose. Thus we have aconite, belladonna, veratrum viride, etc., all having indispensable value. But none of them can accomplish what would seem to me to be an essential requisite in certain highly inflamed conditions at the hyperæmic stage, namely, the diminution, by actual extraction, of the disorganized surcharged blood.

This is best illustrated by referring to a pneumonia occurring in a full-blooded individual, or in any ordinarily so. Note the intense dyspnœa and pain, the natural and inevitable manifestations of the engorged pulmonary tissues. Early in the disease, when the respiration is increased, breathing difficult, the cough violent and distressing, the pulse rapid, full and strong, and the fever high, do not these seem to plead for a lessening of the tension of the blood-current? It seems to me to be unnecessary to argue the statement that the abstraction of blood from these vessels will, by lessening the engorgement, likewise modify the symptoms and hasten the period of repair. A heart, laboring to force the blood through a congested lung, is like a fire engine trying to force a water current through a bent hose; the effort is too great, and something must weaken or give way. The heart, with its increased labor and lessened nutrition, weakens under the work. We may apply our internal remedies for sustaining the heart, but there is no agency so effective for such a purpose as the actual evacuation of enough of the inflamed blood to give relief.

Now, this abstraction is not curing the disease; it simply is intended to shorten and modify the hyperæmic period, giving

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the patient at the same time relief from the symptoms coincident with that period.

But before we proceed further with this reasoning, let us inquire whether bleeding in the healthy person is attended with harm. We may answer the question in the negative, under the reservation of proper care in the act. To my own knowledge, there are no less than five persons, my acquaintances or patients, who make it a practice in the spring of the year to be bled ten or twelve ounces from the arm. Each of these is a person in the best of health, which is not in the least injuriously affected by the loss of blood. In fact, all contend that they are much benefited. Wiltshire quotes from Sir James Paget in this wise: "I can regard those (the practice for adults to be bled as regularly as they went to market) as a series of venesections fairly performed for the determination of what is the influence of the removal of blood up to the period of syncope upon a comparatively healthy person. I think I can say surely that not one of these persons suffered harm." In the absence of any proof to the contrary of the above statement, but with the support of much evidence in its favor, I can safely assume that blood-letting, under necessary precautions, in the healthy, is unattended with harm.

Let us understand that if in health we can lose blood without evil result, in inflammation where the vessels are under enormous tension, and the blood is loaded with fever products, that blood can be taken away from the affected parts without weakening the system, and that the inflamed parts thus relieved are assisted to a speedier process of cure.

Agnew, whose writings are of no less value to the new school than to the old, says, "When I see a headache disappear, as if by magic, after a slight bleeding of the nose; a lung, in pneumonia, relieving itself by a bloody expectoration; an erysipelas affecting a stump after amputation, resisting every remedy, but vanishing in a night after a slight secondary hæmorrhage, I do not hesitate to say that I still find it necessary occasionally to employ the lancet." In this sentence let us note the word *occasionally*. Agnew does not advise the constant or the frequent use of the lancet, but its occasional, appropriate use; not that

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we should carry the lancet in our pocket to keep company with our watch key, and to be used as often as the latter is used; but that it should be at hand for use in properly indicated cases.

In the application of blood-letting to the treatment of disease, certain indications are clearly defined.

The first is an over-distension of the right, and a similar condition of the left, side of the heart. In distension of the right side of the heart there is venous, and in distension of the left side of the heart there is arterial disgorgement. In the first mentioned of these, the venous system is under great tension by reason of the contraction of the smaller arteries, causing a diminished amount of blood in the arterial system, in turn giving rise to an engorgement of the venous system and a hampered right heart, indicated by a small, hard or wiry pulse. In the other condition, the arterial system is under great tension, the left side of the heart is hampered, and the venous system is comparatively bloodless, the pulse being full and bounding.

Having on the one hand a full and bounding pulse due to super-arterial tension, arteriotomy is indicated, which if practiced will tend to equalize the circulation; and on the other hand, a small and wiry pulse, due to venous congestion, venesection is to be practiced with the result of restoring the equilibrium of the blood currents.

In resorting to blood-letting for the equalization of general venous or arterial systems from engorgement, care, of course, is necessary as to proper diagnosis. Wiltshire, whose article in Quain's Dictionary of Medicine, I commend to the student and practitioner as the most concise and satisfactory of any of which I have knowledge, says: "Whether the right or left chambers be taxed, the immediate effect is the same; they are over distended, and cannot get a grip upon their smaller currents. Over-distension paralyzes by removing the *points d'appui* essential for the initiation of muscular contraction; the energy may be there but it cannot be exercised." He further adds, that "It is obvious that the amount of blood which it is necessary to draw, in order to free the embarrassed organ, must vary considerably in different cases. But it may be safely laid down

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as a rule that it need rarely exceed a few ounces. Excess in this respect is the evil which formerly existed." Sir Thomas Watson is quoted in the same article as follows: "I hold it . . . . to be certain that for some special morbid conditions, which inflammation may or may not accompany, general blood-letting and especially venesection, is a patent and life-preserving remedy; that there are many exigencies for which it is not only safe to employ, but unsafe and unpardonable to withold it."

I have no doubt that blood-letting is capable of producing better results than can be arrived at by any other means, not excluding such remedies as aconite, belladonna, veratrum, etc. I must not be understood as advocating the setting aside of these remedies and putting blood-letting in their place, in any other than typical cases. Medicinal remedies are more frequently indicated and of service than is blood-letting. If the latter were to assume the office of the former in every inflammatory condition, inevitable harm would result.

Some time ago, I had, within a month of each other, two patients each with pneumonia. It is not often that we get two patients so like each other, having similar diseases, at about the same time. These two men were large and robust, but addicted to an occasional spree. After one of these debauches, each was attacked with pneumonia. In each the symptoms were identical, the lung engorgement, fever and meningeal congestion being extreme. The proper remedies were administered without relief to the patients. At the suggestion of a member of the family of one of these patients, I was induced to bleed him, three or four ounces from the arm by the lance, and the same quantity from the chest by cups. The relief from the heart tension, dyspnœa, pain, cough, and headache was instantaneous and permanent. In the other case I was not permitted to use this measure, and my patient died. Bleeding saved the life of the first; it would, in my judgment, have also saved the life of the second. I do not mean to assert, or even intimate, that every case of pneumonia should be bled, cupped or leeched; but I do assert that many fatal cases could have been saved by the timely and judicious extraction of blood. I

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say this respecting the treatment by our own school as well as by others.

Constitution, age, condition of the nervous system, heart, kidneys, the nature, place and period of the inflammation determine the need and advisability of blood-letting by one of the methods of lancing the arm, cupping and leeching. In pneumonia, bleeding is best effected by cup or leech to the chest. Bleeding from the arm is not now so frequently practiced, and I myself rarely resort to it. When the pneumonia has passed into the stage of hepatization, blood-letting is of comparatively slight avail, unless simply to relieve the over-taxed heart, but at this time active congestion is over, the system is more devitalized, and there is no longer need for blood-letting. It is early in the pneumonia, when congestion is at its height and the disease is purely sthenic, that cupping or leeching is of value.

In threatened *cerebral congestive apoplexy*, when rupture of the vessels and hæmorrhage have not taken place, bleeding from the arm, or by cups or leeches at the neck, or on the temple, stays the process and averts the stroke. In these cases in which the lesion is not in the affected vessels themselves, I have found bleeding to be of inestimable value. Some practitioners resort to it even when some slight hæmorrhage has taken place, but I would advise it only in threatened increase of the trouble. Bleeding can have no effect upon the already escaped blood, but can considerably aid in preventing further escape, if such escape is due to high tension. It is this high tension that furnishes the best indication for blood-letting. Bleeding should be prompt and free, the amount not to exceed five or six ounces. I have noted brilliant effects from one leech, the capacity of which was less than an ounce. The quantity to be abstracted must be left to the judgment of the operator. Flint very properly says of blood-letting in treating sudden coma from cerebral hyperæmia, that "Its supposed evils are of no moment, taken in connection with the importance of properly diminishing the power of the heart's action, the arterial tension, and the intracranial compression."

In *pleurisy* I find cupping to be of decided advantage, not alone because of the counter-irritation, but as well because of the

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lessening of the vascular tension in the inflamed pleura. It is only in simple acute pleurisy occurring in a strong, or ordinarily strong, individual, that I would resort to general bleeding. If complicated with pneumonia, I would not resort to general blood-letting unless the dyspnœa and pain are marked, but rather would depend upon the use of cups, and the extraction thereby of a few ounces of blood. This remarkably diminishes the pneumonic distress and pleuritic pain. I am not positive, however, that the course of pleurisy is very much curtailed by a resort to blood-letting, nor is there any evidence that it lengthens or aggravates it, but it undoubtedly affords relief to the pain and lessens the fever—two important desiderata in acute pleurisy.

In iritis, the hyperæmia and the intense ciliary pain which accompanies this affection, are each greatly modified by leeches to the temple. The slowness of the natural leech can be overcome in these cases by using the artificial leech of Haurteloupe. Wills advises the leeching to be done in the evening to relieve the nocturnal exacerbations, and directs that the bleeding be favored by hot fomentations. No medicinal remedy is so prompt and efficient.

In the treatment of choroiditis, retinitis and optic neuritis, leeching has its place and value. The congestion and pain together with the strength of the patient, are to be guides as to the time and quantity of the blood-letting.

In *insolation*, bleeding sometimes achieves satisfactory results. The loss of from four to six or seven ounces of blood will very early in the attack, often avert a fatal issue. A tendency to syncope is a contraindication. But early in the attack the indication is positive and clear. There is a decided objection on the part of some practitioners to this treatment, but, in my own experience, only one case of insolation in which I resorted to bleeding died; the large number of others recovered. In this fatal case, I bled to satisfy a bystander, after informing him that it was beyond the power of blood-letting or any other agency to avert a fatal issue.

In *plethora*, sthenic in type, free venesection to the amount of eight or ten ounces is frequently advisable, and nearly always

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beneficial. Arteriotomy is theoretically preferable to venesection, but the former is less convenient and the bleeding is not so readily controlled, though this should not deter the operator, if there is any absobute necessity for a choice of the first over the second. In asthenic plethoras bleeding must, of course, be resorted to with caution, if at all.

This paper has already grown too long, my purpose being to deal in generalities only, reserving minute consideration of the subject for another occasion. The list of diseases and affections given is simply suggestive; it can be added to very considerably. The principle is the same throughout all,—that of affording by blood-letting a speedy exit from the system of unnecessary and devitalized blood, and a quick and decided relief to the tension of the vessels.

Let those who have never been taught the value of blood-letting seek opportunity for its careful study and application. They will find in it no many-headed monster, bent on an invincible course of destruction to those upon whom the art is practiced, but a life-saving principle worthy of their confidence. Let those who, in their younger days, bled on every occasion, and in later years rejected it entirely, consider whether it might not find a judicious place in their practice.

DISCUSSION.

Dr. L. B. Hawley, of Phœnixville, said that he had in his early days, when practicing allopathy made extensive use of venesection; he had abandoned the practice entirely, and was satisfied that his results were much improved thereby.

Dr. J. C. Morgan said that the paper just read brought him back to his early days, when his thumb lancet was as constant a companion as his watch key. Generally speaking he thought that he had pretty good success. He practiced that way for thirteen years. Now, with his present experience and knowledge, he would no more think of resorting to blood-letting than he would of jumping off a house. It was not that there was anything unpardonable in the practice, but it was not necessary. Why should we subject any one to depletion unnecessarily. The

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reconstructive theory of disease now rules, and ought to rule forever in the minds of practitioners of medicine.

DR. CHRISTINE thought that it was impossible to discuss his paper because time had prevented his reading it in its entirety.

A CASE OF PULMONARY TUBERCULOSIS, AND THE RESULTS OF ONE DOSE OF CALC. CARB., 50,000.

BY W. J. MARTIN, PITTSBURGH, PA.

MARCH 31, 1888. Miss Mamie C., æt. 18 years. She has been feeling tired for many months, and very short of breath when ascending steps or going up a hill. She had formerly been a strong looking girl, large and well developed; nothing seeming to tire her. She has noticed for some time a depression or "falling in" of the chest wall over the upper part of the left lung, and now for the first time called her mother's attention to it. The mother became alarmed and brought her to me for examination. The family history is bad; the girl's father and mother have each had brothers or sisters die with pulmonary tuberculosis. I made a very careful examination of the lungs, and found a well marked circumscribed depression over the upper left lung; there were dulness on. percussion, and, on auscultation, rough respiratory murmurs at this place. Everywhere else the lungs were perfect. Expansion, two inches, no cough, not even on deep inspiration, pulse 96, temperature 99.5 in the afternoon. Diagnosis—tubercular infiltration of the upper left lung.

"Where we have circumscribed depressions of the surface of the chest, they follow shrinking of the lung from any cause which may occasion a collapse, but by far the most common cause is caseous condensation of the lungs. The reason of the depression is clear, for when the lung fails to occupy as much space by reason of condensation, the walls become depressed from the force of atmospheric pressure acting upon the outer walls. The upper anterior portions of the chest in the supra and infra-clavicular regions, are the points where such depressions are most fre-

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quently found."—P. 46 of the work on Phthisis Pulmonalis, by G. N. Brigham, M.D., Grand Rapids, Mich.

"Among the earlier and perhaps the symptom of first importance is weariness. Patient says, I wish I could once get rested; feels too feeble for anything; particularly wearied and out of breath on going up hill or up stairs. At this stage may also be noticed the delay in expiration while breathing, the expiration being relatively longer than the inspiration. Then follows the constantly increasing muscular attenuation, and liability to take cold, the short, dry, hacking cough, the complexion showing that the coloring matter of the blood is also diminishing, for this pallor comes in the early stages almost uniformly. If your patient is connected with a phthisical family, the symptoms are all the more significant. If they come from any unexplainable source they are of the gravest import."—P. 68, Brigham on Phthisis Pulmonalis; Prodromic Symptoms.

A singular thing about my case was the absence of cough; on this point I want to call attention to the following from the pen of Dr. Alonzo Clark, of New York, in Pepper's System of Medicine, vol. ii., p. 1167: "I examined the lungs, and found in the upper part of the right a cavity so large that it could have received a fist. I was surprised by the fact that she did not cough. She herself, assured me of that (she was 21 years old); her physician, who was present at the visit, had never heard her cough, and had no suspicion of any pulmonary complication; but, more than all, her mother, who had walked with her, slept with her, eaten with her, travelled with her, and from the beginning of the illness had not been out of her company more than twenty minutes in any twenty-four hours since the disease began, had never heard her cough. Here was a case where the alarm bell of phthisis had never been sounded."

In addition to what was learned by my physical examination, and which was enough for the purpose of diagnosing the disease, but of very little aid in diagnosing the remedy to cure, I gathered the following points: the girl had commenced to menstruate very young; menses always too early and too profuse; menses always preceded by leucorrhœa; sweats very easily and very profusely, especially the palms of the hands and the

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soles of the feet; her stockings are always wet when she takes them off. Temperament decidedly leuco-phlegmatic. Diagnosis of remedy, calc. carb.

On March 31st I gave her one dose of calc. carb., 50,000, and a package of powders of sac. lac., one to be taken every evening. Also instructed her to take frequent walks out of doors, with shoulders well thrown back, and to practice regular, slow, full inspiration and expiration, plain diet, plenty of milk and meat.

The result of the treatment I will give in the words of the mother. She writes:

BROWNSVILLE, PA, May 14, 1888.

It gives me very great pleasure to tell you that Mamie is improving nicely. Her appetite is a great deal better than it was a month ago, and the food seems to be doing her good. She still complains of having pains in her breast near the heart, and where the depression is. She says they are sharp, and that they come on every once in a while. Her feet and hands do not sweat nearly as much, and she does not get so tired after walking or so short of breath. I have measured her twice since we came home, and neither time could she expand more than two inches. The last time she changed she went twenty-five days; she was real sick at the period. I think the lung is filling out some, although the shrinkage is still quite noticeable. Her health is noticeably better. Whenever you want to see her again please let me know," etc.

Under date of June 4th the mother writes:

"She continues to improve rapidly. The lung has filled out evenly with the right, or at least it appears so to me; her breathing seems all right; hands and feet have quit sweating, and all bad symptoms have vanished. She can expand two and a half inches nicely. She has only had pain at two different times in her lung since I last wrote you, and neither time was it severe. She was quite sick last week for a couple of days while menstruating. I really have nothing more to write you about her. We are so pleased that she has improved in the way she has done; we feel very grateful indeed. Enclosed please find," etc.

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On July 2d she writes:

"She was weighed last Saturday with her summer clothing on, and weighed 133 pounds. I am sure she weighs more now than in the spring. She has improved steadily, right straight along, never for one day not feeling quite so well. She had a better time the last time she changed than I ever knew her to have. She has been having a good bit of horseback exercise, and it has been beneficial. I haven't a thing to tell you about her, she seems so perfectly well."

August 5th she writes:

"I have the same old story to tell you about our patient which is so pleasing to tell. She writes me from Washington, where she has been for a couple of weeks, that she is feeling well, and standing the hot weather first-rate, with the exception of getting a little nervous sometimes."

On August 7, just four months and one week from the time of my first examination, I again carefully examined the lungs, and failed to detect the slightest trouble. There was still a very slight depression of the chest-wall at the point already described, but it was so slight that, unless searching for it, I do not think any one would notice it. I dismissed her without medicine, telling her that as soon as she had anything to complain of to let me know. I have not heard from her since. The one dose of calcarea carb., 50,000, administered March 31st, was the only dose of medicine she received. Would a low potency and frequent doses have done as well? I think not.

PULMONARY PHTHISIS.

BY W. C. GOODNO, M.D., PHILADELPHIA.

JUST as I was leaving home for my summer outing, my friend, Dr. Trites, wrote me a pleading letter, urging me to prepare a paper for presentation to the State Medical Society by the Bureau of Clinical Medicine. I did not promise one; but, in the

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solitude of a lonely beach, in New Jersey, fighting mosquitoes, I cogitated upon the objects of the medical society. Prominent in my mind arose the reflection that too much time is devoted to the telling of some "new thing" by specialists (all honor to them) and too little to the elevation of the mass of the profession to the present high plane of established medical doctrine and practice. With this thought dominating my mind, I have prepared a short paper upon that common disease, pulmonary phthisis, aiming, above all else, to impress the importance of its *early diagnosis and vigorous treatment.* Judging alone from the number of cases of this disease which attain advanced development before recognition, we think there must be serious hindrances in the way of its accomplishment or misconception regarding the manifestations of the early stage.

A few preliminary pathological considerations may be *apropos.* Phthisis is an inflammatory disease, generally chronic and involving ultimately all the lung-tissues. Any or all the sequences of the inflammatory process may result, viz.: Consolidation, sclerosis, softening, ulceration, necrosis, calcification, etc.

The primary change may be catarrhal, or consist of connective tissue-changes, or both; but, it matters not which tissue is primarily affected, both are soon involved, one, however, generally in excess of the other. Probably the bloodvessels or lymphatics are often first attacked, although the sheaths about the bloodvessels are lymphatic, and the air-vesicles themselves are now believed to communicate with the lymph-system, and may be looked upon as lymph-sacs. If this view be correct, inflammation of the lung, of the so-called catarrhal variety, possesses a close relationship to the lymphatic system. Changes in the several tissues appear in all conceivable degrees of relative combination. It may be concisely stated, however, that the more acute the progress of the lesion, the more will the changes be found to be catarrhal, with a tendency to the production of a coagulable exudate; and the more chronic, the greater will be the connective-tissue hyperplasia. The rate of progress varies within wide limits. Periods of latency may last for months or years.

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The progress is in waves. It may be characterized as a series of inflammatory storms sweeping over the pulmonary structures, each succeeding storm leaving a greater wreckage of tissue and hope. I wish to emphasize the statement that *the disease has a small beginning.* While the first wave may destroy life, it is generally a little one, and often, very often, is not discovered. Only the slight commotion of system, so apt to be attributed to some other cause, may be noted. I have taken considerable pains in post-mortem examinations of the lungs of persons supposed to be free from pulmonary disease, and have discovered an unexpected number of lesions. Heretofore but little attention has been devoted to the examination of lung-tissue, unless evidences of lung-disease have preceded death; and, unfortunately, autopsies, as usually performed in such cases, result in the overlooking of lesions, unless readily discoverable upon casual inspection. I have found lesions, consisting of small areas or knots of tissue, firmer than the surrounding structures, varying in color and generally closely connected with small bronchial tubes. Microscopically, the air-vesicles are shown to be choked with desquamated epithelium, the connective-tissue of the part thickened, and the bacilli of Koch present in most, even the smallest solidifications, while larger consolidations often possess few or none. I am far from claiming that all of these lesions are phthisical, but I do contend that macro- and microscopically they possess the same general characteristics as phthisical lesions, with the exception of the inconstancy of the bacilli; and that, unless we acknowledge these as the only differential test, we cannot always separate them. In reference to this test it must be confessed that the bacilli are not invariably present in cases presenting pathological and clinical evidences of phthisis. If, then, bacilli are sometimes present in lesions of doubtful character, as, for instance, in the late stage of broncho-pneumonia and in pleurisy, without a history of previous lung-disease, and in small lesions found after death without earlier suspicion of phthisis, and absent (rarely) in persons manifesting full evidence of the disease in question, had we not better practically consider all these lesions as phthisical?

The causation of this affection is a question of exceeding in-

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terest. That it is a disease of civilization, a common outgrowth of gradual vitiation of the nutritive powers, perhaps excited by a germ, seems to be common belief. However this may be, the practical thought I would press is that *inflammation and its sequences are the essence of pulmonary consumption.* The infrequency of favorable therapeutic results depends upon the structural peculiarities of the tissues involved and the nature of the inflammatory products (epithelium and connective tissue), the former, the principal hyperplastic element in the early stage, admitting of but a slight degree of absorption, *mechanical removal* being our principal resource. Connective-tissue hyperplasia, if in moderate degree, causes little disturbance, even if permanent, provided the proliferated epithelium has been emptied from the alveoli. Whatever the *role* of the bacillus of Koch, it has altered our practical attitude toward the disease but little. Its widespread distribution in lung-lesions, but notable absence in a few instances, which all (aside from this test) would consider phthisical (and, as I have observed, its presence as well in the small, unsuspected atrophic lesions, as in the more extensive and progressive changes), diminish, in our opinion, its practical importance. My own experiments have demonstrated some degree of aerial transmission of bacilli from one individual to another, without frequent development of phthisis. Undoubtedly, we all inhale bacilli, escaping the results of their action probably on account of our well-nourished tissues. That nutritive state which repels, cannot be exactly defined. We call it good health, the absence of the scrofulous or phthisical habit, etc. However, as far as we can judge of the presence of good health by tissue and organic perfection, and a correct physiology, not always does it resist the dreaded disease; for persons who appear to be in good health and free from hereditary tendency develop phthisis as a sequence of slight causes—causes which appear to be in common operation as excitants of inflammation of a non-specific character. This leads us to speak of the firm popular and professional belief in heredity. That pulmonary phthisis occurs oftenest in persons with impaired nutrition, whether developed or inherited, goes without the saying; and that the character of malnutrition favorable to the development of a low

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form of inflammation, such as forms the essential feature of phthisis, occurs oftenest in the children of consumptive patients, is certain. In this sense only is the disease hereditary. But that marked evidences of a diathesis are present in the true incipient stage we emphatically deny. After making a diagnosis of beginning phthisis, I am frequently met with expressions of doubt because the patient does not present this habit. The hold which this diathesis has upon the professional mind, is strong and its results only pernicious. It leads to the overlooking of lung lesions until they are extensive, and constitutional deterioration has furnished, what the practitioner has been looking for in vain, an anæmic, diathetic state. Then it is generally too late to materially benefit the patient. Were we to live up to our knowledge in the early diagnosis and treatment of phthisis, most cases would recover, and the disease soon be relegated to a less important position.

Early phthisis cannot be positively diagnosticated from symptoms alone, although several are highly suggestive. The temperature range is most important. When we find a person manifesting for some time a slight afternoon or evening rise, with, as is often the case, an early morning subnormal temperature, we may have very strong suspicion that mischief has begun. It may seem gratuitous to many for me to remark that the thermometer is the only means of determining these temperature fluctuations; but a very little observation will convince any one of the great neglect of systematic, careful thermometric observations I have records of persons who have presented such temperature fluctuations, increasing, decreasing and intermitting for years. I would caution against the tendency among us to *explain away* this symptom, to attribute such fluctuation to some disorder of a simple character, for some coexisting lesion or disturbance often overshadows the feeble, early expressions of this malady.

At the present writing I have in charge two ladies, æt., respectively, 27 and 34 years, neither of whom has ever had hæmorrhage, marked cough, expectoration, chest pains, club fingers, marked emaciation, diarrhœa or hereditary title. (All parents living and in fair health.) Both are neuralgic. One has membranous dysmenorrhœa, horrible vaginismus and occasionally

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tic. The other has severe neuralgic attacks and a feeble heart. Neither is subject to "colds," but the temperature rises occasionally, and a very slight hacking cough may appear, barely noticeable. They waste, grow feeble and miserable. Sea air reduces the temperature of both. Limited and increasing consolidation is to be detected in the lungs of both, with, at times, the rales of localized bronchitis. Cough is usually prominent; but I have often seen patients, who have been long failing with symptoms which had been attributed to all sorts of lesions and conditions of health, who were really sufferers from incipient phthisis, the lung disease having been overlooked on account of the slight degree or absence of cough, expectoration, etc.

Loss of weight bears a close relationship to the temperature and disorders of the digestive apparatus. Later, of course, many factors conduce toward this result. Blood-spitting is certainly highly indicative, but comparatively seldom occurs in the very early stage we are now considering.

Blood-spitting, and, less frequently, pulmonary hæmorrhage, are claimed to occur prior to evidences of consolidation. My experience has led me to consider it a rare precedent. An interesting case in point is that of Mr. M——, æt. 39, who came to me, in the fall of 1878, for an attack of slight blood-spitting, which had continued for several days. He was a man of splendid physique and the best of habits. His skin was ruddy, temperature and pulse normal, and he said he felt well. A most careful physical examination failed to detect disease of the lungs, heart or any other organ. This gentleman has been under my care ever since, and has had five attacks of hæmoptysis, one being quite free. About two years after the first attack, slight consolidation could be detected above the right clavicle, and soon afterwards a small area about the second right rib anteriorly. Indications of anæmia now appeared, the two slight areas of consolidation merged and slight retraction of the chest wall followed. Same failure in flesh and strength and occasional attacks of diarrhœa were also among the symptoms. For several years improvement has gradually progressed with, at present, good health. There are simply the signs of consolidation and retraction remaining.

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Whether hæmoptysis was here the initial symptom or an attendant upon a small lesion surrounded by enough healthy lung to mask the signs of solidification, is a question that must remain unsolved.

If the history and symptoms in a given case lead to suspicion of pulmonary disease, we apply the crucial tests for determining the presence or absence of elastic fibres and the bacilli of Koch in the sputum, and by means of physical diagnosis search for the signs of altered lung-structure. While the examination of the sputum is a simple matter for the expert, it is beset with difficulties, and the results are unreliable, if the steps are carried out by one not skilled in microscopical technique; therefore, most general practitioners are limited to the employment of the general methods of physical diagnosis. This evidences the importance of a familiarity of the most practical character with this subject.

I cannot refrain from urging upon all the necessity of an intimate acquaintance with the normal chest, best taught by that prince of physical examiners, Austin Flint, in his several manuals upon this subject. It is the necessary starting-point for a study of the abnormal. Few, however, are those who have ever systematically studied a single healthy chest. I would also call attention to the importance of the examination of certain neglected regions which often give us the evidence we seek. These are *above* the clavicles, in the axillæ and along the upper inner edge of the scapulæ. To facilitate the examination of the posterior surface of the chest, have the patient examined place the hands upon opposite shoulders and lean forward, thus separating the scapulæ, and thinning and making tense the posterior chest-walls.

In respect to instruments, I think the unaided ear generally preferable to any stethoscope, but the mallet and pleximeter are more satisfactory than the finger for percussion purposes. Hurried examinations, and those made with more than one soft thickness of flannel over the chest, are unsatisfactory.

We are apt to forget that an appreciable degree of dulness upon percussion is only present after considerable consolidation of lung-tissue has taken place. More important, in the earliest

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stage, are alterations of the respiratory sounds, and the presence of the rales of localized bronchitis.

In concluding, I desire to urge upon you the importance of the subject I have brought before you. Could I broach one possessing more of interest to our patients, our families or ourselves? One-seventh of all deaths are due to this fell destroyer. It claims the brightest and best, ending many of earth's bright dreams.

Abandon that infernal, unwritten law of silence toward the sufferers in the early stage of the disease, growing largely out of the doctrine that phthisis is a specific, incurable disease.

Do not be "paralyzed" by a little consolidation. Recognize its great frequency. Hunt for it in all cases presenting a suspicion, and rather err upon the side of finding it. Treat it energetically, persistently. Never relax until all signs of activity cease, and then watch that it be kept down.

Just in proportion as we are led away practically from the doctrine that phthisis is simply a low form of inflammation with a great disposition to spread and terminate in miliary tuberculosis, and that it is an inflammation which may occur at any time, in any one, irrespective of previous condition of health, and that it is an inflammation with but slight tendency to absorption of the inflammatory products, the further we are led from the correct principle of treatment.

Below will be found a slight analysis of 52 cases of phthisis. Part of this number are under treatment. Some are at home, many at various resorts for climatic influences, and the remainder are patients, or rather members of families to whom I am physician, but who are not receiving or are neglecting medical advice for their lung-lesions on account of latency or slight character of the accompanying symptoms. Nevertheless, they furnish valuable material for the determination of questions relating to heredity, etc.

Of this number:

About 5 per cent. are *in extremis*.

Twenty per cent have extensive lung consolidation, and one-half of this number present cavities and symptoms of advanced phthisis.

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About 22 per cent. have well-marked consolidation, with general symptoms of the disease which none well qualified could doubt.

The remaining 53 per cent. have varying degrees of slight solidification, with more or less suspicious symptoms.

Of the total number only about one-fourth present the appearance so many consider indicative of phthisis. An equal number are apparently in good health, judging by color, flesh, ability to exercise, etc.

Heredity would be claimed in about one-half, but is not strong in more than one-third.

About 20 per cent have constitutional deterioration out of proportion to the local lesion, and in a rather larger proportion, cough, expectoration, blood-spitting, even profuse hæmorrhages are not attended by marked disturbances of nutrition.

DISCUSSION.

Dr. Charles Mohr said that we could not but conclude that the single dose of calcarea carb., 50,000th, in Dr. Martin's case, produced the favorable result. This led him to assert that, in the practice of homœopathy, the physician need but rarely to resort to any other therapeutic measure than the administration of the *similimum*. It depends upon circumstances, the idiosyncrasies of the patient and his susceptibilities, whether the high or the low potencies should be used. In phthisis pulmonalis and in lung affections generally where phthisis was threatening, the speaker said that he had seen good results follow the use of calcarea carb. in various potencies, from the 3d, 30th, and even higher. While it may be necessary in individual cases to pursue a more active treatment, still he believed that such measures were resorted to too freely. In one case, then under his treatment, the temperature was 104° F., yet he did not resort to antipyretic measures. Hypodermic injections of one one-hundredth of a grain of sulphate of atropia have been recommended for the relief of the night-sweats. While cases may arise, in which it is necessary to employ these, still we should follow out the line of treatment of Dr. Martin as long as possible. The great-

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est resource of the old-school physicians in cases of phthisis with high temperature, used to be quinine. With the discovery of antipyrine, quinine was doomed. Now, antipyrine is receiving all the praise. The speaker believed that the time would come when the latter drug would be discarded, as was quinine.

He was glad to hear Dr. Goodno say that, in the early recognition of phthisis, lays our best hope of restoring the patient to health. He was also glad to hear him speak so strongly of the importance of the dietetic and hygienic treatment of these cases. These were always important, and should be enjoined, no matter what drug may be prescribed. We should take especial pains to see that the patient gets the most nutritious food. While ordering him to take exercise in the open air, do not permit him to take this exercise to excess; while we enjoin exercise, we should also enjoin rest. Every patient with phthisis pulmonalis developing, should be examined repeatedly with the thermometer. When his temperature is above 100° F., he should take rest. This is very important.

Referring to the preventive treatment of phthisis, Dr. Mohr said that, if we ever expected to stamp out this disease, we should begin our treatment as soon after childhood as possible. For instance, a child is borne of parents who are, of themselves, phthisical, or many of whose relatives have died of that disease; the family physician ought to take advantage of that information, and begin preventive treatment early. In that way it will be possible to stamp out phthisis in a great measure. If these cases are neglected, shortly after puberty the subjects will begin to run down, and get into the condition so ably described by Dr. Martin. Dr. Martin had described a case, in which there was a cavity present, but no cough. The speaker had heard of such cases, but he had never seen them. He had seen a case where the cough was present during the best part of the illness, the lung-tissues were rapidly breaking down, and expectoration was tremendous in amount. But after awhile, when the patient took to her bed, to which she was confined several months, she lost her cough, and that, too, notwithstanding the fact that there existed large cavities in the apices of both lungs. Dr. Mohr then called the attention of the Society to the subject of change

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of climate. The advice given to patients by many physicians to go away for a few months was worse than useless. When it has been decided that the patient has phthisis, and it is necessary for him to seek a change of climate, the speaker expressed his firm belief that that change should be a most radical one. The change should be a permanent one, and to a locality where the patient will thrive best.

Dr. B. W. James said that the point made by Dr. Mohr was a most important one, and one, too, to which the profession paid but little attention. There seems to be a popular idea that the climate is the curative agent. About one-half of the cases that are sent away, are sent to the wrong place; because a place is selected for the simple reason that the physician or patient has friends residing at the place selected. The climate of the place selected should be such as to enable nature to throw off the diseased condition. In many cases the changes can only lengthen life. Each case should be individualized, and sent to a climate to which it is best adapted. It would never do to send a hæmorrhagic case to the warm, relaxing climate of Florida.

Dr. D. P. Maddux, of Chester, said that he had seen patients who had been sent to Colorado, and who had been made much worse thereby. He had seen those same cases decidedly relieved by a warm valley climate. After leaving the Ward's Island Hospital, he was in Texas for some time, and had the opportunity of watching many of these cases. He soon learned that hæmorrhagic cases did much better in a warm climate. On the higher plains of Colorado, he had been told, that, if there was a tendency to hæmorrhage, or if there was any trouble with the heart, a high altitude was not suitable.

Dr. E. R. Snader, of Philadelphia, said that he had spent a year in Colorado, and the opinion among physicians there was that non-hæmorrhagic cases did much better in Colorado than did those who had suffered from hæmorrhages before coming to that State. They also held the opinion that patients with a feeble heart did poorly in that climate. From his short residence in the State, the speaker expressed the opinion that persons who must have a certain degree of moisture in order to be comfortable, cannot get along in Colorado. The points that

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should decide one on sending a patient to Colorado, are that the latter has a strong heart, no hæmorrhages, and feels best on a clear, bracing day.

DR. B. W. JAMES said that, while warm, moist climates tended to produce hæmorrhages, warm, dry climates did not do so. The climate of Southern California is a different one from that of Florida. The latter is almost like a big swamp.

DR. J. K. LEE, of Johnstown, said that, as physicians, we were apt to delay the sending of consumptives away from home until it was too late to do any good. If we could induce a man whose family exhibited a consumptive tendency to remove them to the southern portion of Colorado, or into the middle or northeastern portion of California, we would find that that family of children would gradually outgrow their tendency. But our mistake will always be to order our patient away when it is too late. When we do send them away, is it because we think that their health will be benefited thereby, or is it because we can do nothing more for them? Dr. Lee said that he had some experience with phthisis. He remembered one case that he sent to Colorado. As long as that patient staid there, he did well. He was a man who measured twenty-three inches around the chest, and who was six feet two inches in height. He had a hæmorrhagic tendency. He went to Denver, and remained there for eighteen months. He returned home on a visit, feeling very well at the time. He intended to go back, but circumstances prevented it. He then began to go gradually down. In this case, if the man was to go out there again, he might live longer than he otherwise would. His relatives, on his father's side, were all rugged. His mother, however, has the hereditary taint of phthisis. One lung she has no use of at all. The ribs on that side are sunken. There are three daughters in the family, without any tendency to the disease at all. Dr. Lee then related his experience with a case of acute phthisis which he took to Southern California. The first appearance of the disease was noticed in January. In April following, he went with the patient to California. On the 10th of May he took him home, and on the thirtieth of that month he died. That case was the most acute, and the quickest in its course of any case the speaker had ever seen. He

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thought that he had made a mistake in taking the patient away from his home. His experience led him to say that, if the patient could stand the journey, and had the necessary means for living, he should start for San Bernado, in the low region of California, and gradually work his way to higher altitudes. The best western climate for most phthisical patients is that of Southern California. But they should be sent away before the disease has developed, and they should be made to stay there. He should go away with some one with whom he has become well acquainted. The most homesick man in the world is the consumptive among strangers. He goes away alone, he sees no one that he knows, he becomes despondent, and this despondency kills more people than does phthisis.

WHY EARLY HOMŒOPATHY WAS SUCCESSFUL IN THE TREATMENT OF SYPHILIS.

BY W. B. TRITES, M.D.

In the chronic diseases, Hahnemann has said, speaking of the treatment of syphilis, "In that stage of the syphilitic disease, when the chancre or bubo is yet existing, one single minute dose of the best mercurial preparation is sufficient to effect a permanent cure of the internal disease, together with the chancre, in the space of a fortnight." "The best preparation," he informs us further on, is mercurius vivus, and of the dose says: "I was formerly in the habit of using successfully, one, two, or three globules of the billionth degree (*i.e.*, sixth centesimal dilution) for the cure of syphilis, the higher degrees, however, even the decillionth (*i.e.*, the thirtieth dilution), act more thoroughly, more speedily, and more mildly. If more than one dose should be required, which is seldom the case, the lower degrees may then be required." He also says, in another place, "In my practice of fifty years' duration, I have never seen syphilis breaking out in the system, when the chancre has been cured by internal

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remedies, without having been mismanaged by external treatment."

Mercury in the fifth, sixth, and thirtieth dilutions should be as potent to-day as it was fifty years ago. And yet how many of us can parallel the marvellous results quoted above? From reliable information, I am led to believe that the majority of homœopathists use the above mentioned dilutions in syphilis, yet they are practically unanimous in reporting that secondary symptoms always follow indurated sores.*

The differences in result can *not* be due to the prescription, for the modern physician uses the merc. vivus, prepared and administered as the master directed. Nor can we attribute it to local treatment, for even the old school have declared against cauterizing the initial lession of syphilis.

How can we reconcile such conflicting testimony? Two ways suggest themselves; either Hahnemann's cases were not true syphilis, or else the subsequent histories of his patients were not studied, and hence not recorded.

It is certain that he regarded all venereal sores as syphilitic, for the chancroid was not even recognized until 1816, and its power to produce constitutional disease was questioned until Bassereau in 1852 proved its local nature and divorced it from syphilis forever. Therefore, Hahnemann's reported cases of syphilis, cured without secondaries include many, which we now know, were not syphilitic, and, hence, *could not* have been followed by constitutional infection.

That the subsequent histories of syphilitic patients were not followed up seems probable from the statement "a permanent cure of the internal disease, together with the chancre, can be effected in the space of a fortnight."

Cases of indurated chancre pronounced cured at the expiration of the second week of treatment could only be cured in the sense that the chancre had healed, for the earliest secondaries do not usually appear until a much later period, (six weeks after infection). Patients discharged as cured at the end of a fort-

* The information referred to is derived from numerous letters replying to a series of questions addressed by the writer to physicians throughout the Union.

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night might have constitutional symptoms at a later date and the physician remain in ignorance of the fact.

This tendency to consider the cure of syphilis complete when the initial lesion has healed, is constantly observed in the writings of the early homœopathists, and is a fruitful source of error, leading them to neglect the after history of the patient, and thus miss the later lesions of the disease. In confirmation of this want of care in diagnosis in other writers than Hahnemann let me quote from the British Journal of Homœopathy, vol. xxii., p. 414. We here find a series of cases treated by Schneider, and they are often quoted as evidence of what the higher dilutions can accomplish in syphilis. The author states that he has treated 325 cases of syphilis, and in only four of them did constitutional symptoms develop. Of the 325 cases he reports in full only nine, but among the nine we find the four followed by constitutional infection. We have carefully examined these nine cases, and find that the five cured without secondaries were not syphilis at all but merely chancroids, the remaining four cases, *all* followed by general infection, were, as the report shows, veritable syphilitic chancres.

If, out of the nine fully reported cases, five* were non-syphilitic, while the four syphilitic cases were each followed by constitutional disease, what conclusion can we draw other than that Schneider's 325 cases were all cases of chancroids except the four which developed the general disease? Yet this article of Schneider's has contributed not a little to the confusion which reigns in the homœopathic treatment of syphilis. Other authors could be quoted in which the same error of diagnosis occurs and with the same result, lauding minute doses of medicine for cures which were never wrought.

The statement "I have never seen syphilis breaking out in the system when cured by internal medication" is so opposed to modern experience that an effort should be made to discover the cause of disagreement. It seems impossible that Hahne-

* The report shows that in these five cases the lesions were multiple, their tendency destructive, the discharge from them profuse. Each case developed suppurating buboes, and the cure was accomplished in from six to eight weeks. Absolute evidence of the non-syphilitic nature of the sores.

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mann should have practiced for so many years and not have met with numerous cases of syphilis, and it seems just as impossible, treating them as he did, that secondary manifestations should not have often been seen by him. Want of care in tracing up the histories of his patients will not account for the amazing statement that constitutional disease never followed after he had treated the case. Is it not possible that his views of constitutional infection differed from ours? He lived at a time when the abuse of mercury in the treatment of syphilis was at its height. It was used for every form of venereal disease, gonorrhœa as well as chancre, and its use was pushed to its utmost bounds. As a consequence of this treatment a compound of the disease and mercurial poisoning resulted, presenting horrors of which we know nothing, and this complex was looked upon in Hahnemann's day as constitutional syphilis.

From such drugging as this Hahnemann came to use infinitesimal amounts of mercury. Some of his doses appear to have been so small that it is doubtful whether they impressed the disease at all; others, larger, exerted a restraining influence upon the destructive tendencies of the disease. By using these milder doses of the metal, he escaped its poisonous effects, hence his cases presented none of those terrible ulcerations and bone destructions which were so common under the old régime, and which were due to mercurial poisoning rather than to the syphilis. His patients may have had, and in all probability had, secondary rashes, sore throat and mucous patches, but as these were so mild in comparison with the manifestations attending cases by heroic doses of the mineral, he seems to have regarded them as attendants upon the chancre and not as secondary phenomena.

This explanation of Hahnemann's statement is not hypothetical, but is suggested by the fact that the early writers in our school regard erythemas, papules, mucous patches, and even sore throat as primary affections; considering ulcerations, bone diseases, and other deep processes as evidences of constitutional disease.

Condylomata we recognize as an unmistakable secondary symptom of syphilis, and yet Hahnemann regarded it as a dis-

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tinct disease, and when such growths occurred in the course of syphilis they were attributed to sycosis and not to constitutional infection.

Jahr* defines secondary syphilis "as phenomena which are no longer capable of transmitting the syphilitic disease by direct infection of the individual; hence, it is at once evident that buboes, mucous tubercles and sycosic condylomata, being still endowed with the faculty of communicating the primary disease, cannot be classed among secondary phenomena." From this quotation it is evident that Jahr applies the term "secondary" to that stage of syphilis to which we apply the term "tertiary;" hence, when he says that by his treatment he prevents secondaries, he means tertiary symptoms, and the most of us could unite with him in his experience.

The errors we have pointed out in the views of this disease held by Hahnemann and his followers cast no discredit upon them as enlightened physicians, for they are due not to ignorance but to the faulty pathology of the time. Hunter was the authority of the day, and to him and his teachings the errors are to be credited.

Nor must we forget how comparatively new is our knowledge of that vast number of diseases constituting visceral syphilis. Dittrich's discovery, in 1849, that cirrhosis of the liver could originate by syphilitic infection opened the way to a wide field of research, which has been explored in every direction. To-day we know that syphilis may attack any organ or tissue, and may produce a variety of diseases unrecognized by the physicians of only a few years ago. Visceral syphilis being unknown to the observer, his declaration that the disease can be cured without constitutional manifestations is absolutely valueless.

While we excuse the errors of our fathers, and acquit them of any charge of ignorance or want of truthfulness in their reports, yet we must constantly bear in mind that it was during this period of mistaken pathology when much of our venereal literature was made. We must carefully scrutinize the cures

* Venereal Diseases, Philadelphia edition, p. 161.

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made during this period, and, if we intend to use the remedies advised, be certain in what disease they were prescribed, and what result is due to nature and what to the remedy. For instance, when all venereal sores were regarded as being equally the causes of constitutional syphilis, if a soft sore healed under a given remedy and general infection did not occur, the remedy was credited not only with the cure of the sore, but also with having prevented constitutional manifestations, and passed into our literature as an anti-syphilitic.

What facts of value to the practitioner can be culled from this study of old homœopathy in the treatment of syphilis?

1st. That many of the remedies now advised in its treatment are valueless, because they were first prescribed and were found useful, not against syphilis, but against syphilis compounded with mercurial poisoning. Among these remedies we would place asafœtida, aurum metallicum, carbo vegetabilis, hepar sulphur., lycopodium, phosphoric acid, silicea, and sepia.

2d. Many of the remedies advised in the books of to-day in the treatment of syphilis, were used originally for other venereal diseases not syphilitic, and, while of value in their proper sphere, are valueless in overcoming syphilis.

To this class of medicines we would assign thuja, a remedy frequently prescribed in the treatment of syphilitic condylomata, though in our own experience of absolutely no value. It is a remedy of great use in warts, venereal or otherwise, due to irritation; a form often seen about the glans penis during attacks of gonorrhœa; but in true syphilitic condylomata due to mucous patches situated in moist places, we have never derived the least benefit from the use of thuja.

Nitric acid is a useful remedy in the treatment of chancroid, but we have always failed with it in syphilitic chancre.

Has the homœopathy of the past, then, done nothing to aid us in our efforts to overcome syphilis?

We proudly answer that it has not only done something, but aver that it has done nearly all that has been done to improve and make more certain our treatment of this scourge of the race.

Homœopathy has shown the world why mercury cures syphilis, because it is homœopathic to that disease. Is it not

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singular that all the so-called specific remedies of the old school are capable of producing the symptoms which they cure? Quinine in paludal affections, mercury in syphilis, iodine in the scrofulous diathesis, arsenic and sulphur in the herpetic diathesis. What does it mean other than the truthfulness of our law of cure?

Not only has homœopathy shown us why mercury acts in syphilis, it has done more. It has proved that it acts best in small doses. How great a boon this discovery is to the human race an examination of the literature of syphilis of fifty years ago will show. Mercury, as then used, was even a greater foe to human happiness and comfort than even syphilis. Time after time the old school have thrown the mineral aside, disgusted at its terrible results. Homœopathy has not only shown that it is *the* remedy for the disease, but that it must be used in small doses.

The dose, however, must not be too small. Clotar Mueller has said,* "That in the treatment of syphilis the mercury must be used in strong dosage, from the 1x to the 3x to get good results." The higher preparations have been without value in his hands.

Meyerhoffer, of Nice, says,† "I know of no undoubted case of syphilis cured with the higher preparations." Again he says, "Infinitesimal doses of mercury are utterly inadequate to effect a cure in syphilis, however well the medical agent may be selected."

STAPHISAGRIA FOR THE RELIEF OF MERCURIAL ECZEMA.

BY Z. T. MILLER, M.D., PITTSBURGH.

A MAN with *crab lice* used mercurial ointment until an eczema was developed. The scrotum, penis, and thighs were covered as well as the abdomen to the umbilicus. The rash was bright

* British Journal of Homœopathy, vol. xxiii., p. 76.
† British Journal of Homœopathy, vol. xxiv., p. 361.

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red, raised, and vescicular. The vesicles contained an opaque fluid. Size of the vesicles about that of a millet seed. The itching was violent, the smarting intense, sore after scratching. The lice were not all killed. Lotions of calendula gave no relief. Pure tincture of *staphisagria* applied to the eczema made the man "jump about three feet from the floor," and "hurt like hell for a little while," after which all itching and all lice disappeared simultaneously, and to the great relief of the patient.

That stavesacre kills crabs everybody knows, but that it speedily relieves mercurial eczema as well may not be so generally known.

BABY THERAPEUTICS.

BY Z. T. MILLER, M.D., PITTSBURGH.

WHEN going to a sick baby, *nothing* that is going to help you select the remedy must be overlooked. In order that the symptomotalogy of the following medicines may be applied, it is necessary to ascertain the *kind* of a child you are about to examine.

Is it a *fair*, *fat*, *flabby*, or
Dark, thin, scrawny, or
Big head, big belly, thin neck and extremities, or
Does it like to be washed, in cold or warm water?
Does it crave sweets or sours?
Does it vomit; when and what?
Does it have diarrhœa? Character, aggravation.
Does it have thirst, and how much?
Does it have fever, and when?
Appearance of face.
Appearance of the skin.
Character of urine.
Appearance of the tongue and mouth.
Mental condition.
Sweat, when and where? Amount.
Family history.

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When this examination is on paper, unless you are quite certain of the remedy, don't prescribe until you think you are. WAIT UNTIL YOU FIND THE REMEDY, AND THEN WAIT FOR IT TO ACT.

The *mental symptoms* of children are about the most come-at-able of all they present. In connection with the *objective* symptoms, we are compelled to select the remedy.

Gastro-intestinal complaints make the bulk of baby ills. An occasional well defined meningitis is met, but by far the greatest number of cases of brain disorders are occasioned, or preceded, by some long-drawn-out gastro-intestinal ailment, or perhaps whooping-cough.

The first among the baby remedies we find

ÆTHUSA.—Mentally, *bad humor, restlessness, irritability.* Child lies unconscious, pupils dilated, staring eyes.

Face.—The drawn line from the nose to the corner of the mouth, giving an expression of anxiety and pain, is also an emphasized symptom.

Stomach.—The violent vomiting of curdled milk as soon as taken, with drowsiness after, is the *characteristic.*

Stools not very peculiar, are bright yellow, greenish, watery and slimy, violent tenesmus. Child also drowsy *after* the stool.

ANT. CRUD —The mental group is more marked than with *æth.* The child may be delirious, drowsy, with nausea, *hot and red face* (æth., pale and drawn suffering). Pulse irregular; feverish heat. *Cries when washed in cold water,* better washed in warm water. *Peevish and fretful, does not want to be touched or looked at,* here resembling *ant. tart., cina, silic.*

Stomach.—Belching, vomiting of mucus and bile, renewed after taking food or drink (ars.). *Stomach weak and easily disturbed.* MILKY TONGUE. *Stool watery with little hard lumps,* or *containing undigested food.* Quite different from *æthusa.*

ANT. TART.—Mentally is like *ant. c.* Child will not *allow himself* to be *touched* without *whining* or *crying. Face* is *pale* and *sunken.* (*Ant. c.,* hot and red.)

Tongue covered with a *thick, white, pasty coat, red in streaks, very red, dry in middle.* Ant. crud., thick and white. *Ant. crud,*

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has *no thirst.* Ant. tart., *entire absence of thirst*, or thirst for *cold* drinks.

Stomach.—Vomiting is *forcible, long, lasting until becomes faint*, followed by *languor* and *drowsiness*, much like *æthusa.* Sweat on forehead. *Desire for cooling things.*

Stool.—Watery, slimy, bloody, offensive, not like either *ant. t.* or *æth. Before* stool *cutting colic.*

ARSENIC is the best defined mentally. The great *anguish* and *restlessness—captious, self-willed*, and *tearful*—child that *wants to be carried* (cham.)—differs much from the *antimonies* and *silic.* in that they are *less restless* than *arsenic.* The *antimonies* and *silic.* will lie quiet in the mother's arms, but let any one *come* near, *speak to or touch*, and the cry begins.

Face is *pale* as in *æth.* and *ant. tart.; ant. c.* face is red and hot.

Stomach.—Arsenic, vomits *everything; ant. c.*, water, milk, food. *Æth.*, vomits *curdled milk; ant. crud., mucus* and *bile; ant. tart.*, EVERYTHING forcibly.

Stool.—Arsenic makes the *anus sore. Black, acrid, slimy green mucus*; in fact, all kinds. OFFENSIVE. Somewhat like *ant. t.*, not at all like *ant. c.*, which is watery and lumpy. Slightly like *æth.*, which is greenish, watery, and slimy. None have the excoriation, so far, save *ars.*

BARYTA CARB.—The poor unfortunate; big head and mental weakness; big belly, thin legs, enlarged lymphatics; all making a child that does not want to play, but sits in the corner watching the others.

The face is a sad, sorrowful face.

There is a sensation of hunger, but the appetite is bad. *No vomiting.*

Abdomen distended and hard.

Burning and soreness around the anus as if excoriated, like ars. Frequent passage of blood, with distended abdomen.

There is scarcely any comparison with the preceding remedies. In disposition it is the opposite of *ars.*, nor in peevishness does it reach the degree of the *antimonies.*

BENZOIC ACID.—Stands almost alone. The *child wants to be nursed in the arms.* Will not be laid in the cradle or bed.

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The stools are a *dirty gray* color, like *soap-suds*, and of a horrible odor. The urine *dark* and *strong*, *intensified*. There is much exhaustion. Cold sweat upon the forehead, like *verat. alb.*

CALC. PHOS.—The child is *anxious*, *peevish*, *fretful*. Wishes to *be at home*, and *when at home*, *to go out*. Goes from *place to place*. This suggests *arsenic* in nearly every particular; but as we proceed the difference is apparent.

Abdomen has *pinching sharp colic*, *followed* by *diarrhœa*. *Aching soreness relieved by passing flatus*. Oozing of a bloody fluid from the naval of infants.

Stomach.—There is *oft* and *easy vomiting*.

Vomiting when hawking phlegm.

Stool.—Diarrhœa *during dentition with much flatus*. Stools *green* and *loose*, sometimes *slimy*; a little like *arg. nit.*

CALC. CARB.—Mentally is peevish and irritable.

Profuse *sweat* upon the *head* when *sleeping* or *nursing*. Head *large*, *fontanelles open*.

Abdomen hard and *distended*, otherwise *emaciated*, with *good appetite*.

Stomach.—*Sour* vomiting or regurgitation, particularly of sour food, milk, etc.

Urination.—Painful and difficult, *urine clear* (benz. ac., dark), having a peculiar strong, pungent, fœtid odor. (Benz. ac.)

Stool less characteristic. When the foregoing group of symptoms are present the stool is secondary.

SILICEA.—The resemblance to *calc. c.* is marked in many particulars.

The child is *obstinate* and *headstrong*. *Cries* if even *kindly spoken* to. *Calc. c.*, simply *peevish* and *irritable*.

Both *silic.* and *calc. c.* are indicated in the *troubles* of *dentition*. *Both* have *large heads* and *open fontanelles*. Both have *profuse perspiration on the head*. *Calc. c.*, particularly upon the *forehead*; *silic.*, upon the *whole head*, and *sour*. Both have *hard* and *distended abdomen*. *Silic.*, it is hot.

The *silic.* child wants to be *wrapped warmly*; the *calc. c.* inclines to be uncovered. *Silic.* in this respect resembles *arsenic*.

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Both have *thirst*. *Calc. c.* wants *cold drinks*, more at *night*. *Silic.* is averse to *warm cooked food*, *prefers cold things*.

Silic. is *averse* to *mother's milk*, and *vomits* when taking it, probably because it is *warm*.

Silic. has *nausea* and *vomiting* of what is *drank*, *worse* in *morning*. *Calc., c.* has *canine hunger* in the *morning*.

Stool as in *calc. c.*; the stool is of many kinds and not characteristic.

The *constipation* of *silic.* is characteristic.

The stool is *hard*, and after *partial expulsion slips back*.

Silic. does not present the *urinary* symptoms of *calc. c.*, and in this particular is easy of differentiation.

CHAMOMILLA.—Mentally is a *howler* and *hustler*. *Howls* if not *carried* (ars.). Whining *restlessness* (also ars.). Wants this, then that, which is *refused when offered*. A peculiar cussedness that is found under *cina*, *dulc.*, *rheum*, and *staph.*, but the points of difference are many. With the mental symptoms, *cham.* has *redness* of the *cheeks* or of *one check* only. *Cina*, *paleness* of the *face*, particularly around the *nose* and *mouth*, and sickly appearance around the eyes. *Cham.* is generally covered with a *rash*, red and itching, *heat-rash*. *Staph.* stops short of the ailments of children. *Cham.* can't endure being spoken to, like the *antimonies* and *silic.*

Chamo. has no characteristic vomiting, although there is vomiting of sour food and slimy mucus.

The *tongue* is coated thick *yellow*, or white.

Dulc. and *cham.*, both have *aggravation* from *taking cold*, and *dulc.* also *asks for one or the other* thing, and *rejects when proffered*. The *stools* are quite different, and *dulc.* has *dry heat* of the skin, whereas *cham.* has *moist* hot skin.

Stomach symptoms not marked.

Stool.—Green mucus. Mixed green and *white mucus. Chopped white and yellow mucus. Hot; small; frequent; smelling like bad eggs. Colic before and during stool*, relief after.

Ars. and *arg. nit.* have *green mucous stools*, the *ars.* excoriates. The *arg. n.* is accompanied by much *noisy flatus*, and *cham.* smells like *bad eggs*. The mixed *green* and *white*, *chopped white* and *yellow*, are peculiar to *cham.*

CINA.—Under *chamo.*, *cina* is compared. Child *does not want*

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to be touched (ant. c. and tart. silic.). Can't *bear you to come near it* (ant. c. and tart. silic.). Desires things which are rejected (*cham.*, *cina*, *dulc.*, *cham.*, *staph.*). *Not pleased* or *satisfied* with *anything*, *uneasy* and *distressed* all the time.

Abdomen swollen hard as under *calc. c.*, *silic.*

Face pale (æth., ant. t.) (*hot* and *red*, *ant. c.*, *cham.*), particularly *around* the *nose* and *mouth.*

Disposition to pick or bore the finger in the nose is characteristic; but still more so is the *white*, *turbid* urine, *white*, *jelly-like* urine; benz. ac., dark and strong; *calc. c.*, *strong*, *pungent*, *fœtid odor.* but *clear.*

Sleep is *restless*, *wakes frequently*, or *frequently changes position; waking crying*, kicks clothes off. WILL NOT SLEEP WITHOUT ROCKING. GRINDS THE TEETH.

Stools involuntary; *greenish*, *slimy*, or *white mucus*, with colic *before* the stools.

CHINA is the "won't-do-it" child. *Stubborn*, *disobedient*, longing for dainties.

Face pale or at *times red.*

Restless at *night*, resembles *ars.*, as does the *thirst*, which is for *small quantities.*

The *abdomen* is distended (calc., silic.), tympanitic from flatus, large quantities of which are emitted (arg. nit.).

Stools yellow, *watery; undigested*, *painless. Involuntary after eating; at night; from fruit.* After *severe disease; loss of fluids.*

Colic returns every *afternoon*, but *not so severe* as *ars.*

Great weakness, inclined to sweat, *night sweats* (psor.).

Tongue coated *white* or *yellow* like *chamo.*

GRAPH.—Mentally is something like *china.* The child is *impudent*, *teasing*, *laughing at reprimands.*

Otherwise they are wide apart.

They both have *distended bellies.*

Graph., thirst is for drink to cool one's self internally. *China* wants little and often. They *both* are *weak*, but *graph.* inclines to stretch, but is unable to satisfy it.

Stool of *graph.* is *brown fluid*, mixed with undigested substance of an *atrocious* odor. *Psor.* has a *dark brown fluid* stool, *smelling* like *rotten eggs.*

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Both *graph.* and *psor.* are *scabby*, *mangy*, but the *psor.* baby is *debilitated*, *sweats profusely* from the *least exertion* and *at night*, as does *china*.

RHEUM.—Asks for *different things*, *impetuously* and with *crying; dislikes* even its *favorite things*. *Rheum* is the *sour* baby more ways than one. The baby smells *sour*, so does the *stool*, which is otherwise not very characteristic. There is *colic* and *tenesmus after* stool. *Hepar* has a *sour* stool of *light yellow*, fæcal, *papescent*, *undigested*. *Painless*.

Mag. carb. has *sour* stool, like the *scum of a frog-pond*. *Bloody mucus*, *tenemus during* and *after*.

Merc.—*Sour*, *green*, *bloody*, *slimy* stool, with *tenesmus* even *after* the *stool*.

Rheum wants *various kinds of food*, which becomes *repugnant* as *soon as a little is eaten*.

CAPSICUM.—Child is *clumsy*, *awkward*, especially with *headache*. *Awakens with fright*, *screams* and *remains full of fear*. *Capsicum* resembles *lycop.*, which also wakens *cross*, *kicks*, *scolds*, or wakens terrified as if dreaming. *Stram.* also wakes *screaming*, seems *frightened*, *knows no one*, *shrinks* away or *jumps out of bed*. Clings to those near.

The *stool* of capsicum is *dysenteric*, not *diarrhœic*. It is *mucus; bloody mucus;* tenacious mucus; streaked with *black blood; thin adhesive slimy mucus; mixed with black blood*.

Aggravations after drinking, by currents of air. *Cutting colic before* and *during* the stool, with *tenesmus* and *burning* at anus after.

Thirst, but *drink causes shuddering*.

Tenesmus of the bladder. *Strangury*.

The stools and concomitants of *lycop.* and *stram.* are so different in character and aggravations that no mistake can be made.

COFFEA.—Child *cries*, and *laughs* while the *tears* are *rolling* down its *cheeks*. *Cries* and *laughs* alternately. *Wide awake*, *no inclination* to *sleep*. *Cypriped.* is *wide awake* and *playful*.

Coffea, *stool* is *liquid*, *fecal*, and *offensive*.

ZINC.—Child is *cross towards* evening. *Brain affected*. The *stool* is *dry*, *hard*, *insufficient*, *expelled* with *much pressure*. (Brain

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disease.) *Involuntary* with *stupor* in typhus. Or *frequent, small, involuntary;* pitch-like (nux v.).

Face is *alternately pale* and *red* in brain affections. *Waxy, white,* or *yellow* in *typhus.*

Cold sweat upon the *forehead* as with *calc. c., verat. alb., ipec.,* and *tobac., benz. ac.*

CUPRUM.—*Cross* and *irritable, changeable mood* (coffea), or *indifferent* and *dull in brain affections.*

Summer complaints of children *where the brain is affected.* Diarrhœa *squirts out,* as does *crot. tig.,* which is *sudden,* and *gamboge,* which *squirts* after a *somewhat prolonged pressure,* or *phos.,* which *pours out* like a *hydrant.* With *cuprum,* there is much wind passed, as with *arg. n.* and *aloes.*

The *sleep* of *cuprum* may be *heavy* or *comatose,* or the patients may be *sleepy* with *inability* to sleep.

CAUSTICUM.—Child is *timorous, fears to go to bed alone.*

Stool is knotty, like sheep's dung, or *liquid, fecal, white mucus.* Agg.—*Cold air striking the abdomen.* (See CAPS.) *After fresh meat.* After stool, *nausea; salt water brash. Aversion to sweet things* (op., arg., n.). *Fresh meat* causes *nausea* and *water brash. Smoked meat agrees* (calc. ph.). Enuresis. Involuntary urine when coughing or walking.

PULSAT.—Child is *peevish, changeable; pale; chilly.*

Stomach vomits after *being chilled* or *deranged* by *fruits, pastries,* etc. So far not very unlike *arsenic.*

Stool.—Watery, only, or *usually, during* the *night.* Greenish yellow, slimy, very changeable. Stools like bile, preceded by rumbling in the abdomen.

The *dysenteric* stools are *clear yellow, red* or *green* slime with tenesmus. Discharge of *blood* and *mucus* during stool. Face pale, fainting.

Frequent stools of *mucus* after *dysentery.*

Thirst rare, but when he does drink takes little and often, it provokes inclination to vomit.

Puls. has *many* symptoms like *ars.,* but probably not so intense. The *child, stomach, stool* and *thirst* are quite like *ars.,* but *ars.* has much *pain* with the diarrhœa, *puls. has not. Ars.* is

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always thirsty; puls. may be. *Puls.* diarrhœa < during *night.* Ars. < after midnight, eating and drinking.

ACONITE.—The child has *spells* of *rage. Ailments* following *anger* and *chagrin.*

These spells of rage are characteristic of *acon.*

Child's fever is red hot, restless, cross.

Thirst continues, and for great quantities.

Stools.—At first are *frequent, scanty,* loose, with *straining.* Small, *brown, painful,* at last *bloody; dysentery.*

They may be like *chopped herbs.*

Inflammatory diarrhœa or *dysentery during hot days* and *cold nights.*

FERRUM PHOS.—The mental condition not particularly defined.

The *skin* is *hot* and *dry.*

Thirst great, for *much water.*

Stools are frequent, *green, watery,* or *hashed mixed* with *mucus, scanty; straining* at *stool;* also *retching.* Child *rolls* its *head* and *moans, eyes half open; face pinched. Urine scanty. Pulse* and *respiration* accelerated. Starting in sleep. *Stools contain undigested food.*

Stools may be of *pure blood,* bloody mucus or bloody scum. *Yellowish* or *whitish brown* with *blood,* like *bloody fish-brine. Green watery* or *green mucus,* with *blood,* no pain; *blood dark* or *light.*

Sudden deathly sickness at *stomach. After* eating, *nausea* and *vomiting. Sour, setting teeth* on *edge. Vomiting* after *eating.*

Complaints during dentition.

The aggravation of bloody serous stools is from midnight till morning.

Retention of urine with fever in little children.

Nose-bleed of bright blood in *summer complaint.*

MAGNESIA PHOS.—Another of the *tissue remedies* occupies considerable place in children's troubles, and is destined to climb still higher.

The *colic* of *children* has been relieved *many* times; it is spasmodic, *intermittent colic,* relieved by *bending double* and *by heat,* also by eructations. There *may* or *may not* be *diarrhœa.*

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Dr. H. C. Allen, in the September *Advance*, gives the complaints of teething children, and especially "*Spasms during* dentition, WITHOUT FEBRILE SYMPTOMS." Whereas *bellad.* is hot, hot skin, hot head, rapid pulse. I think I have recently seen *mag. ph.* relieve spasm where there was fever present, the bloated abdomen with spasms leading to the selection.

BALSAM COPAIVA—AN EXPERIMENT.

BY EDWARD CRANCH, M.D., ERIE, PA.

IN pursuance of the recommendation of Dr. A. P. Bowie, in these *Transactions* for last year, I used the balsam copaiva to anoint the catheter in a case of senile prostatitis, with retention. The patient became frantic, and refused a repetition, saying very energetically, "wash it off, wash all that stuff off, it burns like fire." A dilution was used internally, with no effect beyond a slight aggravation.

THE REPORT OF THE BUREAU OF SURGERY.

THE Report of the Bureau of Surgery was presented by Dr. John E. James, in the absence of the Chairman, Dr. L. H. Willard. The following papers were presented:

Surgical Cases, by W. R. Childs, M.D.

Remarks on the Antiseptic Treatment of Carbuncle and Kindred Inflammations, by W. B. Van Lennep, A.M., M.D.

Surgical Cases, by Charles Gangloff, M.D.

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SURGICAL CASES.

BY WILLIAM R. CHILDS, M.D., PITTSBURGH.

1. MR. L., white, æt. 39, city fireman, admitted October 8th, 1887, presents himself with enlarged scrotum, and with a history of having been struck in the part by the nozzle of the hose. It gave a great deal of pain for a few days; one week later, swelling appeared, and now there is a condition simulating hydrocele in every symptom but one—there is a lack of translucency. Diagnosis: Hydro-hæmatocele. Operation: A free incision was made in the right side of the scrotum, the walls being found much thickened, and inclosing a bloody water. The testicle shows signs of melanotic degeneration. It was decided that removal of the testicle entire was necessary, but that operation was postponed, as the patient's consent had not been obtained Temporarily, a dressing of a calendulated solution was applied. ℞. Arnica 3x every two hours. Eighteen days later, owing to the extreme amount of inflammation and the decided progress of the degeneration, the patient consented to the removal of the organ. In the meantime the wound had healed, with the exception of the opening for the drainage-tube. Operation: Incisions were made on both sides of the cicatrix, cutting it out entire, ligating the vessels and cord, and amputating as high as possible. The wound was dressed with iodoform, and closed with interrupted sutures. A good recovery was made, and the patient discharged from the hospital three weeks later. During December and January he resumed his work in the Fire Department. About February 1st, 1888, he received several falls, and on the 10th he was readmitted to the hospital. Through the courtesy of Dr. C. P. Seip, who was in charge of the Surgical Department at this time, the patient was referred to me for operation. I found him in great distress, suffering from pain in the renal region and neck. There was also an enlargement of the cervical, axillary, and inguinal glands. The right side of the scrotum was enlarged enormously, of a brownish-black color, and devoid of any sensation, except as

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caused by its weight when unsupported. From a small opening in the lower part of the scrotum, there exudes a thin, dark-colored, granular discharge, devoid of odor. The general appearance of the man was very much changed. He was emaciated in the extreme, very anxious, almost hopeless. His first words were: "Well, doctor, do you think you can do anything for me this time?" My reply was: "An operation will give you some ease and prolong your life." The patient being willing, he was anæsthetized and prepared for operation. The entire right half of the scrotum was removed, the incision encroaching somewhat on the left side, and exposing to view the left testicle. The wound was closed with interrupted sutures, and dressed with iodoform and antiseptic gauze. Seventeen days later the wound had healed, and his improvement was such that he insisted on returning to his home, being anxious to cast his vote in the ward election held February 28th. I did not hear anything more of the man until the latter part of April, when I saw in the daily papers a notice of his death, which, it was said, had been caused by "black cancer."

2. Mrs. L., white, æt. 58, patient of Dr. M. J. Chapman, admitted October 17th, 1887. Diagnosis: Scirrhus of breast. The history is that common to these cases. A small nodule appeared some time ago, slowly increasing in size, hard, movable and painful. October 19th, she was prepared for operation. In order to conserve as much tissue as possible, the incisions were made on a line with the ribs, and the entire breast removed, together with several of the axillary glands. Drainage-tube was inserted, the wound dressed with iodoform, and the edges united with iron-dyed silk, the whole surface being covered with antiseptic gauze. The wound was daily irrigated through the drainage-tube. On the eighth day the stitches were removed, the wound having healed by first intention. On the seventeenth day she was discharged, cured.

3. A. W., æt. 16, male, white, admitted June 7th, 1888. Diagnosis: Gunshot wound. In January last, while hunting, and carrying his gun, muzzle down, behind him, it was accidentally discharged, the contents lodging in his heel, lacerating the tissues, and comminuting the bone. During five months

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he had been treated by local physicians, who had removed shot and other foreign material, including a number of spiculæ of necrosed bone. When he came to the hospital, his foot was much indurated, inflamed, and very painful, discharging a foul-smelling pus from several openings on both the outside and inside of the foot. The probe reveals much diseased bone. The patient was anæsthetized, and two incisions were made at right angles, below the internal malleolus. The entire os calcis and astragalus, with a portion of the cuboid and scaphoid bones, were removed. A counter-opening was made on the outer side of the foot, the wound was thoroughly irrigated and packed with jute and oakum. ℞. Arn. 3, every hour. On the second day the dressings were removed, the wound washed and dressed with balsam of Peru. These dressings were continued, gradual improvement taking place until the 7th of August, when the patient was discharged. There was some flexion of the great toe, which was corrected by adhesive strips passed under it and drawn up over the dorsum of the foot. The remedy throughout the case was silic. 3x.

4. Charles C., æt. 13, white, admitted June 15th, 1888. Eight months ago this boy fell from a chestnut tree, sustaining a compound fracture of the right thigh, about the middle of the shaft, the lower end of the bone tearing and protruding through the pantaloons. The fracture was reduced and treated by a neighboring physician. Some time after apparent recovery a fistulous opening occurred, from which there has been a constant discharge for several months. The limb is about two inches shorter than its fellow, but otherwise there is no deformity. Operation: A free incision was made through the fistulous opening, and a portion of the femur, measuring two inches in length and entirely denuded of periosteum, was found lying alongside the shaft of the bone, the fractured ends of the upper and lower fragments having been drawn together by contraction of the muscles and firmly united. The loose piece of bone was removed, the wound irrigated, and packed with jute saturated with balsam of Peru, thus insuring healing by granulation. Arnica 3x, for forty-eight hours, was administered, and, after that, he-

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par 3x and 6x. In four weeks the boy was discharged, entirely cured

5. A. S., æt. 30, white, German, admitted October 12th, 1887. While at work at the Bessemer Steel Works, this man was struck by a steel ingot which swung around, catching him on the outer and middle portion of the thigh. The force of the blow was so great that it broke the femur in several places, and forced the ends of the larger fragments completely through the muscles, carrying them so far that they formed a right angle one with the other. The laceration was nearly twelve inches long, but fortunately did not include any of the larger vessels and nerves. A simple extension apparatus was applied, the ends of the bone placed in apposition, and the wound dressed with a solution of calendula. ℞. Arn. 3x every two hours. Reaction from the shock was very gradual, but he made a good recovery, and at the time he was discharged from the hospital, was as well as ever, with no deformity, except a shortening of about two inches.

6. A. D., æt. 22, Arabian. Diagnosis: Fracture of the skull. This man was brought to the hospital in the police patrol wagon. We could get no history from the patient, nor could we find any one who knew anything about him. He neither speaks nor understands our language. Examination reveals a large scalp wound, which had almost healed by granulation. There was some little discharge of pus, and the probe gives evidence of a fracture and depression of the outer table of the skull. Bathing and rest, with the ordinary treatment for scalp-wound, was all that was deemed necessary until the morning of the fourth day, when the nurse in charge reported that, during the night, the man had had a chill (?) which lasted thirty minutes. Orders were given to have the patient carefully watched, and any unusual symptoms to be immediately reported. At 6.30 P.M. the nurse reports the patient having *another chill.* The resident surgeon, Dr. H. G. Briggs, examined him, saw that it was a *convulsion* instead of a *chill,* and at once summoned me. I called the surgical staff of the hospital, and ordered preparations for an immediate operation. The patient having been anæsthetized, incisions were made to the left of and parallel with the sagittal

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suture and at right angles with this, extending toward the left ear, together making a T-shaped incision. The triangular flaps were dissected up, reflected and a button of bone removed with the trephine. The edge of the left parietal bone was found depressed, and carefully elevated. There was considerable hæmorrhage, which was checked by the application of hot water. One single wire suture was used to approximate the edges of the wound, which was dressed with iodoform and antiseptic gauze. ℞. Arnica 3x every two hours. The patient rested well during the night, and took some nourishment in the morning, having been completely conscious since recovering from the effects of the anæsthetic. He, by signs, told us that he had some pain in the head, for which bell. 3x was given. His pulse and temperature varied. but slightly from normal. On the third day free suppuration set in, the wound was dressed with boracic acid compress, a 10-grain solution being used. He remained in the hospital one month, during which time there was no return of the convulsions, and no untoward symptoms presented. The only remedy he received was belladonna.

REMARKS ON THE ANTISEPTIC TREATMENT OF CARBUNCLE AND KINDRED INFLAMMATIONS.

BY WM. B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

WITHOUT entering into a discussion concerning the similarity or identity of these inflammations, carbuncle, furuncle, etc., I shall consider them, for the sake of treatment, as one.

Again, nothing need be said as to their causation and pathology, whether due to micro-organisms or not, whether these are distinct or the same, farther than that they are all characterized by a virulent inflammatory process, resulting in a more or less extensive slough formation. This necrosis is to a certain extent due to pressure, but it undoubtedly differs from that

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found in some inflammations whose location under firm unyielding structures explains the consequent tissue death; for example, the so-called "bone-felon." Occurring, however, as they do, in soft parts, we must look rather to the virulence of the inflammation as the slough producing element, while their rapid local spread, the frequent lymphatic involvement, both vascular and glandular, and, in instances, their more or less general dissemination in neighboring as well as distant parts, would indicate a highly active, if not a specific poison, as the exciting cause.

Acting on the prevalent germ theory of to-day, it behooves us to attack this poison with powerful germicides or antiseptics, agents that will kill thoroughly and rapidly. Again, in view of the intense pain usually present, we should strive to use an agent that is, if possible, a "pain killer" as well. Finally, a "permanent" or rather long-lasting dressing should be applied under which healthy granulations can fill the solution of continuity.

Mercurial bichloride is probably the most active germicide, but we are all familiar with the intense and long-continued burning that follows its application in any strength. Carbolic acid, on the other hand, has long been used to deaden surfaces to which nitric acid is to be applied, the burning sensation produced being but momentary and followed by a more or less continued numbness. It forms furthermore a rather superficial slough, and does not eat to a dangerous extent, a fact, however, rather against its efficiency. To act rapidly and thoroughly as a germicide this drug must be used in considerable strength, this being the main cause of its decadence among the antiseptics.

I cannot better illustrate this method of treatment than by briefly outlining a few cases.

In April last, I saw, with Dr. Gumpert of this city, the largest carbuncle either he or I had ever met with. The man, over sixty years of age, was rapidly failing, the temperature was over 103°, the pulse rapid, weak, and small. On the back of his neck was an immense cavity into which both open hands could have been easily placed, surrounded by unhealthy, extensively

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undermined edges. It extended from ear to ear, up under the scalp nearly to the vertex, and down the back to both scapular spines. The whole surface was covered with ugly sloughs in different stages of separation, several large ones protruding from beneath the scalp flap. The destructive process had involved all the subcutaneous fat, and, going deeper, had dissected out a number of the muscles. There was the characteristic stench and an abundant discharge of unhealthy pus, but, above all, the patient suffered from the most agonizing pain, for the relief from which he pleaded most piteously. The treatment had been, in the main, poultices, washing with weak carbolized solutions, and a well-selected remedy, with stimulating diet; the sloughs had been, from time to time, dissected off as they became loose, but this had been followed on the previous day by a severe hæmorrhage. With such an extensive surface to treat I feared the too free use of carbolic acid; the upper and lateral portions, where the process seemed active and spreading, threatening important structures and localities, and the pain was the most complained of, were accordingly painted freely with a 30 per cent. mixture in glycerine. The same was lightly wiped under the remaining edges and around some of the sloughs which were cautiously and sparingly snipped off. Iodoform was blown on, and the whole cavity packed with gauze of the same (50 per cent.), care being taken to push it into every crack and crevice. In subsequent dressings, to avoid toxic symptoms, the iodoform insufflation was discarded and a weaker gauze substituted (10 per cent.). Cotton in abundance was put over this and a gauze bandage held the whole in place. He was urged to wear the dressing for three days at least, more cotton being bandaged on as the discharge came through.

The pain ceased immediately and did not at any time recur. He slept well, his appetite picked up, his temperature came down, and his pulse gained volume and strength. The discharge, of course, was tremendous, and the stench almost unendurable. On the third day, when the dressings were removed, a number of the sloughs were found to have separated, and the whole surface was bathed with healthy pus. The dressings were changed every two to four days for about three weeks,

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when Peruvian balsam was substituted. He made an uninterrupted recovery. When seen a few days since, the cicatrix was good, and there was no deformity from contraction of the same.

Another case, treated in my out-patient department, at the Children's Hospital, was seen at a much earlier stage. The carbuncle was situated between and a little below the scapulæ, and was, roughly estimated, about four inches in diameter. It had the characteristic honey-combed appearance, was intensely painful and accompanied by the usual prostration and systemic disturbance. Several of the openings were united by incisions, the whole interior thoroughly wiped out with crude carbolic acid, and a dressing applied as in the former case. He was directed to wear it, if possible, a week, and, his condition being so poor, to go to bed and be visited by one of the out-door staff. Relief was immediate, and he was able to come to the dispensary regularly.

These two cases typical of the early and advanced stages will, I think, suffice to exemplify this method of treatment as applied to carbuncle.

I had the good fortune, some time since, to try this treatment on a medical friend for a similar inflammation, and his description of his sensations has been to me very interesting. He had poisoned himself at an autopsy, the point of infection being the right ring finger. Knowing the sad experience of some of my colleagues with similar accidents, I was very anxious to give carbolic acid a trial. The dorsum of the thumb and adjoining portions of the hand were much swollen and red, there being, however, no localization or sign of fluctuation. The characteristic lymphatic implication was present, *i.e.*, red streaks up the arm and enlarged sensitive glands, and two small abscesses were forming on the left side of the face and neck. These were slit open and wiped out with strong carbolic solution. They gave no further trouble. A large flaxseed poultice was applied to the hand, and on the next day an intensely painful doughy mass, about the size of a walnut, developed on the dorsum of the thumb. This mass was freely incised, and found to contain a firm adherent slough. Carbolic acid, 50 per cent. in water, was injected

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and thoroughly rubbed in. The doctor likened the sensation to a coal of fire for about a minute, after which the pain ceased suddenly, entirely, and permanently. Iodoform dressings were used as in the former cases.

The temperature which had been ranging from 101° to 103°, came down rapidly to normal. The recovery was uneventful. The doctor noticed one symptom which has since led me to change the after-treatment in some cases, *i.e.*, that the hand felt as if it "ought to be dressed" at the end of forty-eight hours. The dressings were found to have caked, and this would seem to occur where the lesion is small or the discharge scanty. With this single restriction I cannot insist too strongly on long dressings in these cases.

I was first led to use carbolic acid for these inflammations about two years ago when I met with a sort of epidemic of furuncles, notable for their number and recurrence. To prevent their spread the first boil or crop was incised crucially and wiped out with carbolic acid, either crude or in strengths running down to 50 per cent. in glycerine or water. I have since had occasion frequently to repeat this treatment with good results, and to extend its application to kindred conditions, *i.e.*, slough producing inflammations; to carbuncle and the results of all kinds of poisoned wounds, as in the cases prescribed; to neglected abscesses, as those so frequently met with in the palm; to gangrenous masses, etc. Also, in several instances, where the scraping of a softened scrofulous gland has been refused, very nice healing has followed the use of the acid.

Carbolic acid has received considerable attention in this connection of late.

Dr Bidder reported to the Berlin Medical Society (*Berliner Klinische Wochenschrift*, No. 14, 1887) one hundred cases of furuncle treated by parenchymatous injections of 3 per cent. carbolic solution. The needle is pushed into the core from the side, in from one to four places, and from a few drops to a half or a whole hypodermic syringeful injected each time. Cloths wet with the same solution can then be applied. He says some of the fluid escapes through the fistulous opening, from which it must be inferred that he waits until the boil has burst. The

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introduction of the needle he found very painful, but a numbness soon followed. A burning and stinging sensation is felt later on, but by the next day the patient is practically well, absorption of infiltration and healing being soon complete. He found incisions unnecessary. Other experimenters have since discarded this treatment as entirely too painful. In the discussion that followed, Guttmann called attention to the great sensitiveness of the pathogenic micro-organisms of furuncle, the staphylococcus pyogenes aureus and albus, to carbolic solutions. Von Bergmann recommended early incision to prevent spread and destruction, and Lassar scraping with the sharp spoon, which he claimed was not particularly painful.

Verneuil, in a communication to the Paris Academy of Medicine, January 17th, 1888 (*Revue de Chirurgie*, February 10th, 1888), recommends the use of phenic acid spray in carbuncle and furuncle. He discards the large incisions, excision, caustics and the thermo-cautery, and, from a number of observations, claims this method will immediately arrest the pain and cause resolution or even abort the affection. He uses a 2 per cent. solution, and sprays for about two hours daily in from two to four sittings. Compresses, wet with the same, are applied in the interval. In the discussion of the paper on January 24th, the opinions differed. Some attributed the results to the tepid spray, others again doubted that such weak solutions could have either antiseptic or anæsthetic effects.

Acting on this suggestion I tried the spray in a case of diabetic gangrene I saw some time since with Dr. R. C. Smith, in which pain was a prominent and very intractable symptom. The relief was of short duration after each application, and absorption was soon made apparent by the urine. Nothing, in fact, antiseptic or not, would arrest the process until the proper diet caused a disappearance of the sugar. Verneuil's two failures were in cachectic diabetics with severe anthrax and serious complications.

English surgeons, on the other hand, seem to have been more interested in the question of erasion, *i.e.*, excision, combined or not with scraping. Paget's advice "to do nothing locally" has been discarded, and, instead of merely keeping up the strength,

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active, radical, and rational local measures are being experimented with.

In the *British Medical Journal* for March 24th and 31st, Parker, Owen, and Page recommend erasion, the former by excision aided by scraping, and the two latter by scraping alone. They condemn the use of caustics. In the same journal (April 7th, 1888), Mr. Henry Downdes, of Liverpool, advocates milder treatment, the above being, in his opinion, too severe for ordinary cases. He has treated carbuncle for some years by injecting, three or four times a day, a 1 to 40 solution of carbolic acid. This is begun as soon as an opening, however small, appears. In the interval it is covered with a rag soaked in the same. The slough ceases to extend, wastes to shreds, and swelling and hardness disappear.

Mr. Teale (*Liverpool Medico-Chirurgical Journal*, January, 1888) recommends scraping for carbuncle; the same to be supplemented by smaller crucial incisions and scrapings in the contiguous carbuncular skin. The resulting cavities and crevices should be well soaked with pure carbolic acid or its glycerole. Iodoform and an absorbent dressing complete the treatment.

Dr. Robert F. Weir (*Medical Record*, July 14th, 1888) reports five cases of carbuncle; four treated by incision and scraping, and one in which he supplemented this by injecting 1 to 20 carbolic acid into the reddened tissue beyond the reach of the spoon. Eight or ten drops of the pure acid were thus used without producing constitutional effects.

Dr. Chappel, in the same journal (June 9th, 1888), writing on the treatment of carbuncle by carbolic acid, speaks of the difficulty (noticed by ourselves) of introducing the needle and making the injections into the hard inflamed tissues. He has used pure carbolic acid locally "with gratifying results." In the early stages a daily application of a few drops will arrest the process. When the disease is more advanced he introduces into each suppurating point one or two drops, painting the intervening tissue with the same, and repeats this procedure daily for three or four days. By this method he has aborted every case that presented early, and the more advanced ones have responded and improved from the first application.

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He has not had an opportunity to employ this treatment "in those severe cases where the necrosing process has extended many inches under the skin, and would hesitate to apply pure acid to such a large surface at one time." He proposes to treat a small surface each day, or to employ a weaker solution of the acid. My first case comes to the point here.

This method comes nearest to my idea of the best treatment, plus incision and with but one single application of the acid in suitable strength, to be repeated only if required. While I have never found it necessary to have recourse to the more radical operative procedures, I should not hesitate to use them if, at any time, the plan I have mentioned fails.

To sum up, it seems to me that to be efficacious, carbolic acid should be used in considerable strength, not less than 30 per cent. to 50 per cent., or, at times, the crude drug, when there is no danger of toxic absorption in consequence. It may be well to bear in mind that the mixtures with glycerine are less active than those with water. Too much stress cannot be laid on its anæsthetic effects. The application of the acid should be combined with incisions to relieve tension and allow exit for discharges. I have employed this treatment, and from what I can infer all writers have done the same, only when the boil was ripening or the carbuncle had begun to show its characteristic openings. Verneuil's method may be of use before the inflammation has become localized, before pus or sloughs have formed. The spray can be alternated with cataplasms soaked in the same solution. It is certainly worthy of a trial, inasmuch as he claims that it has in his hands aborted the disease.

I have no doubt several of my colleagues have given this treatment a more or less extended trial, and I trust the ensuing discussion will throw some valuable light on the management of this very painful and, at times, intractable, destructive, and even fatal class of inflammations.

DISCUSSION.

Dr. L. H. Willard, of Allegheny, opened the discussion by appointment. He said that the remedy that would give the

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greatest relief in these cases of carbuncle was the one mentioned by Dr. Van Lennep. He used it strong in all cases. But he also pays strong attention to the constitutional condition. There are in these cases fever, soreness of muscles, etc., and these give you the indications for the remedies in the first stages. By giving the indicated remedy at such a time we diminish the sufferings of the patient. In the last case he had treated there seemed to be no possibility of doing anything on account of the age of the patient. There were great redness and swelling and infiltration. He pencilled the surface over with carbolic acid in weak solution. His nights were made better by the administration of arsenicum, rhus tox., and belladonna, as indicated. The speaker never thought of treating a case of carbuncle without constitutional treatment; nor did he think that Dr. Van Lennep would do so, although he had not made mention of such measures in his paper. There is always some constitutional defect in these cases, and this necessitates the employment of constitutional measures. The first symptom that takes our attention is a loss of appetite. In old persons that is an important point to consider. Unless the appetite is kept up, the patient will in all likelihood die of exhaustion. The best internal remedies for these cases are rhus tox., belladonna, arsenicum, and sometimes phosphorus.

In the treatment of carbuncle in the first stage, Dr. Willard said that he then began his use of carbolic acid. He never made any incisions, as he did not think it necessary to do so. He took a bodkin or eyed probe and dipped it into the acid. He then inserted it into each of the little openings of the carbuncle, and manipulated it in the part until the least drop of blood came. This he does every day. It was his experience that the acid took away the pain to a great extent. When the patient's nights are restless, rhus tox. 6 helps.

Dr. Chas. M. Thomas expressed his satisfaction at the character of Dr. Van Lennep's paper. He would first say that to his mind the paper represents the type of work that should be presented by our bureaus; something brief and practical; something derived from the writer's personal experience, and something that will draw out discussion. As to the pathology, etc.,

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of carbuncle, we can read all about that in the books. As to his own experience, Dr. Thomas said, the use of carbolic acid has been of recent date, that is, within the past year or year and a half. Up to that time he had treated almost all carbuncular inflammations by poulticing and caustic potash. He introduced the solid stick of caustic potassa into the little openings of the carbuncle if they were present; if they were not present, then he made punctures, and passed the potash through the skin and into the deeper structures. He had found that after these applications of the caustic potash the pain and tension had been rapidly relieved. He had also used the carbolic acid in the same way. The relief was perhaps prompter after the carbolic acid; still he would say that the difference between the two was not great. The carbolic acid is perhaps easier of application and makes less of a muss. If potash is carelessly applied it may produce unpleasant caustic effects. Besides the treatment of carbuncle as recommended by the essayist, Dr. Thomas had also treated this disease by scraping and excision in a few cases, and with very pretty results. He had simply cut the carbuncles out entirely. He had either made an incision and cut the carbuncle entirely away, or he scraped it out with a spoon. Dr. Van Lennep says very properly that we must use in these cases an active germicide, a pain killer, and a dressing that can be left on for a considerable length of time. The speaker said that he would add to these requisites the property of rapidly breaking down connective tissue, and producing sloughs. In this one respect he would consider the caustic potash as superior to the carbolic acid. He believed that the course of the disease would be shorter under the caustic potash treatment than under that of carbolic acid. Carbolic acid is, however, the less painful of the two.

With regard to the strength of carbolic acid, Dr. Thomas said that it made some difference as to the menstruum in which the acid was applied. If it be mixed with oil or glycerine, particularly the former, it is comparatively inactive. It is well enough in oil as an antiseptic, but it will not occasion any irritation. If he were to use it in glycerine he should use a solution of the strength of 75 per cent., or even stronger. In fact, the

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nearer you can approach to the pure acid, the more successful will be the treatment.

The speaker also said that he did not see how it was possible to carry out the practice of daily puncturing and injecting the acid into the carbuncle by the hypodermic syringe. This practice, he should think, would be very painful. Sometimes it is a very difficult one, as the edges of the carbuncle are often hard and brawny and almost like cartilage. He believed that where it was at all possible the application should be made once for all. Strong solutions or the crude substance should be introduced to the greatest depth and well towards the margin of the infiltrated tissue. If the limit cannot be reached by any of the openings present, then an opening should be made. But in all cases the operator should be sure that he is acting on carbuncular tissue and not on simply inflamed tissue.

As to dressings, Dr. Thomas said that he could conceive of nothing better than the antiseptic dressing recommended in the paper. In the early stages of the affection he believed incisions frequently called for. They may not be, however, full crucial incisions reaching all through the tissues, but should be sufficient in extent to relieve congestion and tension, and also give us a road-way into the deeper part. The younger and the healthier the individual, the more free would he make these incisions. In old and debilitated subjects he would hesitate about incising.

The speaker would throw out a word of warning by calling attention to the fact that Dr. Van Lennep's paper was on the *antiseptic* treatment of carbuncle. If we did not closely follow antiseptic principles, or were to cut into, inject, and cauterize a dirty carbuncle, we certainly would not be following out Dr. Van Lennep's idea. In his early pre-antiseptic experience Dr. Thomas said that he had seen some very serious results following incision and operative treatment of various sorts in carbuncular inflammations, and no doubt because the operation was done on a dirty surface. The incision made through the dirty carbuncle and into healthy tissue resulted in inoculation of the latter and the production of an erysipelatous inflammation, and in one case death followed.

With regard to the constitutional management of these cases

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he did not believe that it was the intention of the essayist to treat of that part of the subject. He meant only to deal with the local treatment. He, himself, had derived more benefit from the internal use of chininum arsenicosum in cases of carbuncle and kindred affections than from any other remedy, though he had also used lachesis, rhus tox., arsenicum, etc.

Dr. John E. James said that he had seen some very serious results and one death follow the treatmeut of carbuncle by the old method that Dr. Thomas has spoken of. This was years ago, before antiseptic methods were in vogue. He had seen several cases almost die where the mass had been large and slough formed, the skin thickly congested and raised, and bleeding freely, and where it was almost impossible to save the patient from death, resulting from the exhaustion of the loss of blood, in addition to the already great drain on the system. So, for eight years, he had not made use of free incisions, but instead he made small incisions into which the potassa can be introduced. He had also used the carbolic acid in strengths varying from one in twenty to one in five. If that did not relieve he increased the strength of the solution still more. The value of carbolic acid thus applied has been proven in England in the treatment of that affection known as malignant pustule, a disease somewhat similar to carbuncle. The method particularly advocated in cases of the malignant pustule is the hypodermic injection of carbolic acid beneath the mass. As soon as the pustules become raised, instead of injecting the carbolic acid into the mass, it is injected beneath it. In that way many cases have been cured without much constitutional disturbance.

In the treatment of carbuncle, Dr. James said that he had seen more relief follow the application of cold water than from anything else. He had not used carbolic acid as a caustic as recommended in the paper. He would ask Dr. Van Lennep if cicatrization was any more rapid by his method. In the old method cicatrization was very slow and very tedious; sometimes, after proceeding awhile, it would then break down again. If Dr. Van Lennep's method of treatment causes cicatrization to take place more rapidly than do other methods, then we have gained another point. By the cold-water treatment the cicatri-

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zation is more rapid, and, when formed, is firmer than by other methods he had tried. He knew that the administration of hepar, not higher than the 3d, frequently repeated, would relieve the pain of the carbuncle quicker than would either morphia or rhus tox.

For the prostration accompanying these cases there was no remedy better than tincture of china. He has about a half teaspoonful of the drug mixed with a half glassful of water, and then taken at short intervals in divided doses. The tincture of cinchona seemed to possess decidedly more active properties than any of the alkaloids of cinchona.

Dr. Joseph E. Jones described a case of carbuncle which he had treated by injecting with the hypodermic syringe a few drops of carbolic acid into the base of the lesion. A small slough formed around the puncture of the needle, and gave exit to the pus. Otherwise, no slough formed. In answer to a question by Dr. J. K. Lee, he said that his internal remedies in this case were belladonna, rhus tox., and afterwards arsenic; but none of them relieved pain. The carbolic acid did that. He should try this method in his next case of felon.

Dr. W. B. Van Lennep said that it was not his intention to bring up the question of internal medication in his paper, which dealt entirely with the subject of the antiseptic treatment of carbuncle and kindred affections. Of course, he had used internal remedies, principally arsenicum, carbo veg., rhus tox., hepar, silicea and chininum arsenicosum. He had also used the tincture of cinchona, as recommended by Dr. James, with excellent results. The question of long and short dressings had been raised. A short dressing should be a wet one. The best wet-dressing is creolin. If a dry dressing, it should stay in place from four to seven days. As to the question of operating, we should not lose sight of the fact that the majority of carbuncles occur in old debilitated subjects who cannot stand the shock of an operation. So, in the majority of cases, we must do something to check the process and kill pain. He had never used the caustic potash; he was glad to hear of Dr. Thomas's experience with it. He should use it when he desired to produce rapid sloughing.

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Dr. Van Lennep thought that the openings of a carbuncle ought to be united by an incision, to permit of the ready escape of the discharges. He agreed with Dr. Thomas respecting the weakening effect of glycerin and oil on carbolic acid. He was opposed to poultices, for there is nothing better than moisture and heat for the development of germs. Cicatrization had been beautiful after the treatment advocated in the paper. Carbolic acid is desirable as a caustic, by reason of the fact that it does not eat very deeply. In closing his remarks, the speaker begged leave to differ with Dr. Jones. In the case of inflammation under the unyielding periosteum, if we do not relieve the tension promptly there will be death of the parts from strangulation.

Dr. Jones said that he could not agree with Dr. Van Lennep. This injection of the carbolic acid makes a slough wherever the needle enters, and thus it produces an opening which permits of the escape of the discharges.

SURGICAL CASES.

BY CHARLES GANGLOFF, M.D., PITTSBURGH.

A Coffee Bean in the Air-Passages for Fifty-two Days.—Recovery.

R. S., æt. 3 years, came under treatment on April 27th, 1888. He was of a strumous diathesis. He had suffered from general eczema since he was three months old. He had hitherto been under old-school treatment. His parents, as a forlorn hope, had decided to try homœopathic treatment. His back, chest, and abdomen were entirely covered with a dry, pimply eruption; the skin underneath was very hard. The genitals, scrotum, and folds of the nates were covered with an offensive and humid eruption. He also had boils on the neck. The eyelids were inflamed, and surrounded with pimples. He could not sleep on account of itching. ℞. Hepar 30x, four doses a day.

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As the child showed immediate and steady improvement, the prescription was continued for seven weeks, when the skin became entirely natural, with the exception of the scalp.

On May 26th, while playing with coffee-beans in his mouth, he was seized with an attack of coughing, and one of the beans went into the larynx. The boy choked. A doctor was sent for immediately; in my absence an old-school doctor was called. Nothing was done by him beyond recommending that tracheotomy be performed.

From that time until evening the boy did not complain of any symptoms, when he was taken with slight attacks of mucus rattling in the windpipe, and an occasional dry, hollow, croupy cough. ℞. Spongia 3x trituration, in water; aconite, if needed.

The child seemed well until the morning of May 28th, when he had what his parents called an attack of croup. There was a large accumulation of mucus in the larynx, which he was unable to expectorate on account of spasm of the glottis. Severe dyspnœa; choking when lying down; pulse 120, temperature 102°. ℞. Veratrum viride and kali bichrom.

May 29th. His condition was not altered. Pulse 120, temperature 102.1°. ℞. Kali bi. 3x and tartar emetic 6x.

At 6 P.M., Dr. W. J. Martin was called in consultation. Child vomited large quantities of tough phlegm. There was a great deal of rattling in the bronchi. The prescription was continued.

May 30th. Child was up and played about; good appetite; still had rattling in the bronchial tubes. Pulse 96, temperature 99°. Tartar emetic 6x every three hours.

June 1st, 9 A.M. Severe dyspnœa. Respiration 54; pneumonia threatening, Pulse 124, temperature 102.2°. ℞. Kali bi. 1x and tartar emetic 3x.

At 5 P.M, Dr. J. H. McClelland was called in consultation. We found the child better. Pulse 108, temperature 101°. Prescription continued.

June 2d. Pulse 100, temperature 99°. ℞. Kali bi. 3x and tartar emetic 30x, three doses of each daily.

June 8th. Child was progressing nicely; occasional vomiting of tough, yellowish phlegm; was seized with a spasm. Pulse 124, temperature 102.4°, respiration 42. ℞. Belladonna 3x.

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At 5 P.M., severe rattling in larynx and chest. Pulse 120, temperature 102.1°. ℞. Kali bi. 1x, tartar emetic 3x.

June 9th. Improved. Pulse 114, temperature 99.4°. ℞, Continued the treatment.

June 10th. Improved. ℞. Kali bi. 2x, tartar emetic 30x.

From this day the child progressed nicely until June 26th. when an abscess commenced to form between fold of nates. Hepar 6x was given, and the abscess was opened.

July 3d. Hepar 30x continued.

July 2d. From loss of sleep, anxiety, etc., the mother of child became sick.

July 12th. Raymond is up and playing; feels well. Rattling in larger bronchi yet.

July 17th. During a severe spell of coughing, the bean was expectorated this morning.

Rupture of the Bladder.—Recovery.

O. W., æt. 21, while playing baseball at New Castle, became overheated; he afterward sat on a cold stone, which caused retention of urine that night.

July 12th. Did not pass any water, yet went to play another game. Great soreness in region of bladder followed. Went to a physician who, after fruitless efforts, could not get the catheter through (though he hurt the boy badly) That night, after applying hot cloths and hard rubbing of the abdomen, the boy could pass some water, and undertake his journey homeward.

July 13th. When seen, found bladder very much distended, and pelvis full of urine. Pulse, 130; temperature, 104°. Severe pain in region of bladder with occasionally dripping of a little water. ℞. Belladonna 3x. Urine drawn by catheter. Hot applications.

July 14th, 8 A.M. This day I had to draw the water three times. Pulse, 80; temperature, 99°.

3 P.M. Catheter used. Pulse, 84; temperature, 99.2°.

8 P.M. Catheter used. Pulse, 90; temperature, 100.3°. ℞. Belladonna.

Was called at 10 P.M. Patient had had severe chill at 9 P.M.,

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lasting half an hour. Pulse, 128; temperature, 103.3°. ℞. Aconite 1x.

July 15th. Reports that, after midnight, he commenced to sweat, and feels very weak now.

8 A.M. Passed a little water, with severe burning. Abdomen very tender. Diarrhœa. Continue hot applications. ℞. Arsenicum 6x.

8 P.M. Passed a little water; no fever. ℞. Arsenicum 6x.

July 16th. Had a chill at 5 A.M. Passed water, though scanty, with burning. Slept some. ℞. Arsenicum 6x.

July 17th. No chill to-day. Pulse, 90; temperature, 100.2°. Spot above the pubic bone, the size of a quarter, reddened. ℞. Arsenicum 6x, changed to hepar 6x on the 18th.

July 21st. Progressed nicely; abscess formed, which I lanced one inch above crest of ilium, on the left side; one and a half pints of pus removed.

July 22d. While I made call, patient wanted to urinate; none came through penis; all through opening I had made. Lanced scrotum, and removed half a pint of pus. ℞. Hepar 6x.

From this date, my patient progressed well. Appetite and sleep returned, and a week afterwards he would have considered himself well, if the urine would have come through the natural passage, but all was voided through the opening I made.

July 29th. In order to give the rent in bladder a chance to heal, I intended to introduce a soft catheter, and leave it in the bladder. After inserting it, no water came, though the boy did not urinate for three hours. On removing the catheter, I found it clogged with pus, showing that the rent was on the posterior surface, in the neighborhood of the prostate gland.

I injected through the penis a solution of calendula, four times a day. This came from the opening first with pus, then clear, but never mixed with urine. A few days later, the urine commenced to flow a little from the urethra. This increased daily until August 14th, when it ceased coming from the opening, and the boy could hold his water better than he did any time before his sickness.

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GENERAL BUSINESS.

THE Chairman of the Bureau of Materia Medica, DR. Z. T. MILLER, of Pittsburgh, presented the following report:

The report of the Bureau of Materia Medica is simply stupendous, but the character of it is such that it will not take up much of your time.

This is the first of a five-year system of our existence. The work in hand, as you all know, is the preparation of a repertory to Hering's *Condensed Materia Medica.* The work presented here shows what has been done. As the retiring Chairman, I beg leave to make a few suggestions, with reference to this work. Some of it is *most excellent.* Some of it, while very good, does not compare, in degree of excellence, with the balance. Now it seems to me, that it should *all* be excellent before it is put into cold type. The requirements of such a book brook no mistakes, no omissions and no ambiguity. It must be uniform in arrangement, exhaustive of the material worked up, and, *above all*, ready for *quick reference.* The material here presented does not, in every instance, come up to this standard. Now I respectfully submit that, in order that the end aimed at and desired, be obtained, the whole manuscript be allowed to remain in the hands of the Bureau for another year, to be gone over, and edited in such a manner as will secure to every member of this Society a repertory, reliable in every detail.

You will all recognize the necessity for this matter appearing in one volume. We already have two sections in the *Transactions* of 1887. I, therefore, recommend that the repertory be printed and paged alone, and furnished the members in unbound sheets, so that, when complete, each member can bind to suit his taste, the pages to be issued any time during the year, or as soon as edited.

DR. H. C. ALLEN, editor of the *Advance*, has agreed to publish the repertory, but I think we will want it *before* it can be run through the *Advance* at the rate of fifteen or twenty pages per month. At that rate it would require something like thirteen years to finish.

It is my belief that the book would meet with an extensive

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demand from all over the country, if gotten up in proper shape. I have already one letter from Texas, inquiring about it.

The above report, by Dr. Miller, was freely discussed.

DR. JOHN E. JAMES finally moved that "The repertory, as reported, be referred to the Bureau of Materia Medica for revision, and in that state be furnished to the Committee on Publication, and that the same, when revised, be published in the *Transactions* of the Society, and paged separately from the *Transactions*." This was adopted unanimously.

At the closing session, DR. Z. T. MILLER moved a reconsideration of Dr. James's motion, as above reported. Carried.

A number of substitutes for this motion were, in turn, offered and discussed.

DR. JOHN E. JAMES moved that the portions of the repertory presented be published in a separate volume from the *Transactions*, and that each member of the Society be assessed two dollars to defray the cost of publication of the same.

DR. W. B. TRITES offered an amendment to the above, providing that the parts of the repertory be bound in paper.

DR. Z. T. MILLER offered another amendment, providing for the incorporation in the first volume of the repertory, of the rubrics presented last year, and of the repertory of "Tongue Symptoms," by Dr. Fornias, published in the August and September numbers of the *Hahnemannian Monthly*.

Both of these amendments were accepted, and, with the original motion, were unanimously adopted.

DR. JOHN E. JAMES then moved that members who had joined the Society at the present session, be exempted from paying the assessment. Carried.

THE COMMITTEE ON PRESIDENT'S ADDRESS then reported as follows:

PHILADELPHIA, September 20th, 1888.

Your Committee, to whom was referred the Address of the President, begs leave to report as follows:

The address, as a whole, and especially its careful collection of medical statistics, and its masterly argument in favor of wiser and more equitable legislation regarding our State public charities, merits the highest approbation of this Society, and the thanks of an interested public.

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As relating to the suggestions and recommendations contained in the Address, we offer the following recommendations:

A. As to the proposed change in the time and place of holding the annual sessions of this Society, the By-Laws, Article I, Section 1, provide that the Society, at each annual meeting, shall decide the time and place for the next meeting. This leaves it free to try any new method at any time, yet without binding it to any particular custom. Hence we do not recommend any modification of the By-Laws, but suggest that the subject of a change in our custom be considered, when the time and place of next year's meeting is being acted upon.

B. As to the publishing of papers outside of the Society's *Transactions*, we recommend

1st. That, in Article VII, Section 1, of the By-Laws, the final words, "previously published," be superseded by the words, "published previous to its presentation."

2d. That a new section be added as follows: "Section 2. Any paper may be published in a medical journal at any time subsequent to its presentation, provided that it be prepared in duplicate, and the original retained in the custody of the Committee of Publication."

3d. That sections "2, 3 and 4," of Article VII, of the By-Laws, be renumbered 3, 4 and 5, respectively.

C. As to the collection, collation and promulgation of statistical information, we recommend, for adoption, the following:

"*Resolved*, That the Bureau of Organization, Registration and Statistics be, and hereby is, requested to adopt as its 'special subject' the collection and collation of statistics relating to the comparative results of homœopathic and non-homœopathic treatment of disease in its various types, and in both hospital and private practice, that the utmost care be exercised, to secure accuracy in the entire work, and that all necessary information substantiating the reliability of the facts and figures obtained, be embodied in the annual reports of the Bureau."

D. As to the need of hospital charities in the State, we recommend the following for adoption:

"*Resolved*, That, for the ensuing year, the Committee on Legislation shall contain at least five members, representing various

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sections of the State, and that its special duty shall be to prepare and publish, as soon as practicable, an address, embodying such statistical information, and such other matters as may be deemed necessary to influence legislation favorable to the establishment and support of homœopathic hospitals for the insane, and for other homœopathic charities; and, further, that the Committee be authorized to publish an edition of said address, sufficient to furnish copies to each member of the legislature, and to all physicians who may need them."

PEMBERTON DUDLEY, M.D.,
J. K. LEE, M.D.,
W. J. MARTIN, M.D.,
JOHN E. JAMES, M.D.,
JOSEPH E. JONES, M.D.,
Committee.

The report of the Committee was received, its recommendations adopted, and the By-Laws ordered to be changed in accordance with its provisions.

The Committee appointed at the last meeting to examine into the charges of unprofessional conduct preferred against a member, presented a written report. All the members of the Committee were absent. The report was therefore referred for action to a committee consisting of Drs. J. Richey Huner, Horace F. Ivins, E. M. Gramm. After examining into the matter, the Committee begged leave of the Society to defer its final report until the meeting in 1889. The report was accepted and the Committee continued.

DR. CHARLES MOHR offered the following:

Resolved, That, in addition to the five members of the Bureau of Materia Medica, a number of collaborators be appointed annually, in order to give workers on repertorial work an official standing.

Carried unanimously.

The bills for miscellaneous printing and postage were then presented, and ordered to be paid.

The election of officers was then held, and resulted as follows:

President, Dr. William B. Trites, Manayunk; First Vice-President, Dr. C. F. Bingaman, Pittsburgh; Second Vice-Presi-

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dent, Dr. John Malin, Germantown; Treasurer, Dr. J. F. Cooper, Allegheny; Corresponding Secretary, Dr. E. R. Snader, Philadelphia; Recording Secretary, Dr. J. Harwood Closson, Germantown; Necrologist, Dr. W. R. Childs, Pittsburgh; Censors, Dr. S. F. Shannon, Dr. Clarence Bartlett and Dr. Sarah J. Coe.

Pittsburgh was selected as the place for holding the annual meeting in 1889.

The following Bureaus and Committees were then announced:

PÆDOLOGY.—Dr. J. Richey Horner, Chairman, and Drs. E. M. Gramm, S. F. Shannon, C. H. Lee, H. M. Bunting, D. B. Umstead, George Getz, E. E. Briggs, Thomas Reading, L. W. Reading, W. C. Powell, T. H. Grimes, F. C. Gundlach, D. P. Maddux, W. W. Wolf and J. H. Closson.

SANITARY SCIENCE.—Dr. Pemberton Dudley, Chairman, and Drs. J. H. McClelland, T. M. Johnson, J. R. Horner, E. L. Oatley, H. M. Bunting, W. F. Marks, B. W. James and Thomas Reading.

PATHOLOGY.—Dr. W. J. Martin, Chairman, and Drs. W. K. Ingersoll, A. R. Thomas, C. C. Rinehart, J. M. Maurer, R. W. McClelland, Jos. Rodes and H. C. Chisholm.

OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.—Dr. Joseph E. Jones, Chairman, and Drs. H. F. Ivins, W. F. Bigler, W. H. Winslow, F. W. Messerve, R. W. McClelland and W. H. H. Neville.

MATERIA MEDICA.—Dr. J. C. Guernsey, Chairman, and Drs. C. S. Middleton, A. P. Bowie, Charles Mohr and Z. T. Miller. *Collaborators*, Drs. T. J. Gramm, H. F. Ivins, Clarence Bartlett and W. H. Bigler.

GYNÆCOLOGY.—Dr. B. F. Betts, Chairman, and Drs. E. W. Mercer, T. M. Bulick, F. M. Boyer, J. W. Thatcher, Samuel Starr, M. J. Chapman, M. L. Crumpton, J. J. Detweiler, H. E. Kistler, H. N. Martin and M. Preston.

OBSTETRICS.—Dr. Sarah J. Coe, Chairman, and Drs. C. F. Bingaman, J. N. Mitchell, A. M. Marshall. E. F. Pettingill, O. B. Gause, O. S. Haines, Theodore M. Johnson, W. B. Trites and Isaac G. Smedley.

CLINICAL MEDICINE.—Dr. W. C. Goodno, Chairman, and Drs. E. R. Snader, W. B. Trites, William A. Haman, Clarence

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Bartlett, W. W. Van Baun, B. C. Parsons, W. F. Edmundson, D. R. Harris and C. C. Reinhart.

SURGERY.—Dr. J. H. McClelland, Chairman, and Drs. C. M. Thomas, John E. James, W. A. Van Lennep, L. H. Willard, Charles A. Wilson, M. J. Buck and F. P. Wilcox.

LEGISLATION.—Dr. Hugh Pitcairn, Chairman, and Drs. J. H. McClelland, L. H. Willard, Pemberton Dudley and H. C. Chisolm.

COMMITTEE OF ARRANGEMENTS.—Allegheny County Society.

BUREAU OF ORGANIZATION, REGISTRATION AND STATISTICS.—E. R. Snader, M.D., Chairman.

DELEGATES TO AMERICAN INSTITUTE OF HOMŒOPATHY.—J. H. McClelland, M.D. and J. C. Burger, M.D., of Pittsburgh, and A. R. Thomas, M.D., of Philadelphia.

The Society then adjourned.

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CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—Name and Object.

This association shall be known as the Homœopathic Medical Society of the State of Pennsylvania.

Its object is the advancement of medical science.

ARTICLE II.—Members.

This Society shall be composed of active, honorary and corresponding members who shall be chosen in conformity with the By-Laws.

ARTICLE III.—Officers.

The officers of this Society shall be a President, two Vice-Presidents, a Recording Secretary, a Corresponding Secretary a Treasurer, a Necrologist and a Board of Censors, consisting of three members, who shall be chosen at such time, in such manner and for such a period, and shall perform such duties as the By-Laws may direct.

ARTICLE IV.—Amendment.

The Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting; provided, that notice of such intended alteration or amendment shall have been given to the Society, in writing, at the annual meeting next preceding.

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BY-LAWS.

ARTICLE I.—Meetings.

Section 1. The annual meeting of this Society shall be held at ten A.M., at the time and place decided upon at the annual session next preceding.

Seven members shall constitute a quorum for the transaction of business.

Sec. 2. The elected officers of the Society shall have power to direct such other meetings to be held as they may judge advisable.

Sec. 3. Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the committee of arrangements.

ARTICLE II.—Officers.

The officers shall be elected by ballot at each annual meeting of the Society, and shall enter upon their respective duties on the first day of January next succeeding their election.

ARTICLE III.—Duties of Officers.

Section 1. The President shall preside at the meetings of the Society, preserve order therein, put questions, announce decisions, and appoint committees not otherwise ordered. He shall deliver an address at the opening of the session.

Sec. 2. The Vice-Presidents, in the order of their election, shall perform the duties of the President, in his absence.

Sec. 3. The Recording Secretary shall keep a record of all the proceedings and resolutions, and of all discussions that may occur in the Society; authenticate, by his signature, all papers and acts of the Society, when the occasion requires it, and bring before the Society any business needing its action not otherwise presented.

Sec. 4. The Corresponding Secretary shall receive and preserve all letters addressed directly to the Society; open and main-

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tain such correspondence as shall tend to advance its interests; give at least two weeks notice to the members of all meetings of the Society; keep a record of all members, with the date of admission of each; present all communications to the Society; notify all committees of their appointment and of the business referred to them, and notify all members of their election. He shall be *ex-officio* chairman of the Bureau of Organization, Registration and Statistics.

SEC. 5. The Treasurer shall notify, annually, all members of arrearages, collect all money belonging to the Society, and make all disbursements ordered by the Society. He shall furnish at each annual meeting, a written report of his receipts and expenditures, and a statement of the condition of the finances.

SEC. 6. The Necrologist shall, upon the death of a member of the Society, prepare a suitable obituary and present it to the Society; he shall also forward a copy, properly engrossed, to the family of the deceased member, if so ordered by the Society.

The report of the Necrologist shall be presented in connection with the report and papers of the Bureau of Organization, Registration and Statistics.

SEC. 7. The Censors shall receive and examine the credentials of candidates for membership, and shall report to the Society, for election, such as may be found to be properly qualified.

Their report can be made in its regular order, or at the close of the report of any bureau.

ARTICLE IV.—MEMBERSHIP.

SECTION 1. *Active.*—A candidate for active membership may present to the Board of Censors, a written application, signed by himself, accompanied by a certificate from two members of the Society in good standing, that the applicant has received the degree of Doctor of Medicine from an incorporated medical college, that he subscribe to the doctrines of *Similia Similibus Curantur*, and that he sustains a good moral character. If found qualified, he may be elected a member. He shall not, however, be considered a member until he has paid an initiation

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fee of five dollars (which includes the first year's dues), and signed the Constitution, either in person or by proxy.

Any active member removing from the State wishing to retain his membership, shall notify the Society to that effect; otherwise his name shall be dropped from the roll.

Any active member who fails, either to attend the annual meeting or to send a paper once in five years, or to pay his dues, shall, upon vote of the Society, be dropped from membership.

Any member who shall be unable to comply with the requirements of this Society may be continued as an active member without payment of dues, by vote of the Society.

SEC. 2. *Honorary.*—Any homœopathic physician, not a resident of Pennsylvania, who, from his superior attainments, may be judged worthy, may be elected an honorary member at any annual meeting, but no more than two shall be elected in one year.

Such honorary members shall have all the privileges of members, except the right to vote and to hold office.

SEC. 3. *Corresponding.*—Any homœopathic physician residing outside the United States may be elected a corresponding member at any annual meeting, but not more than two shall be elected in one year.

Such corresponding members shall have all the privileges of members, except the right to vote and hold office.

ARTICLE V.—DUES.

Active members shall pay annually, in advance, the sum of three dollars towards defraying the expenses of the Society.

The published proceedings of the Society will be furnished only to those members who are not in arrears.

ARTICLE VI.—BUREAUS AND COMMITTEES.

SECTION 1. The following Bureaus shall be appointed as hereinafter provided:

One of Materia Medica and Provings.

One of Homœopathic Institutes and Clinical Medicine.

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One of Surgery.
One of Obstetrics.
One of Gynæcology.
One of Pathology and Pathological Anatomy.
One of Ophthalmology, Otology, and Laryngology.
One of Pædology.
One of Sanitary Science.
One of Organization, Registration, and Statistics.

SEC. 2. Each bureau shall be composed of not less than five members.

SEC. 3. Each bureau shall present, in its annual report, a resumé of the discoveries and progress in its special department, together with the papers presented for discussion. The bureaus shall report in order of rotation each succeeding year.

SEC. 4. The Bureau of Organization, Registration, and Statistics shall receive all credentials of delegates to the Society; receive and preserve all reports from local or State societies, colleges, and other institutions; keep a record of the number of members admitted and withdrawn from the Society; solicit an exchange of publications with other State societies, and perform such other duties as may be directed by the Society. From these data, the annual report of the bureau shall be prepared.

SEC. 5. Immediately upon the close of the report of a bureau, the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall, in conjunction with the President, select his associates, and the list of members of the bureau shall be announced before the close of the session.

SEC. 6. If any member of a bureau shall resign or decline to serve, the chairman of the bureau shall fill the vacancy by appointment, and notify the Corresponding Secretary of the fact.

SEC. 7. The following Standing Committees shall be appointed, as hereinafter provided for:

A Legislative Committee.
A Publishing Committee.

SEC. 8. Each of these committees shall consist of at least three members, to be appointed by the President.

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SEC. 9. The Legislative Committee shall give special attention to all legislation involving the interests of the Society.

SEC. 10. The Publishing Committee shall publish and issue the Transactions to all who are entitled to receive them, within three months from the date of the meeting, unless otherwise directed by the Society at its annual meeting.

The Recording and Corresponding Secretaries and the Treasurer shall constitute this committee, but the number of members may be increased at the discretion of the Society.

ARTICLE VII.—PAPERS AND DISCUSSIONS.

SECTION 1. Each paper presented to the Society shall be through its appropriate bureau. All papers to be presented by any bureau shall be in the hands of the chairman thereof at the opening of the session; and it shall be the duty of each writer to prepare an abstract, which will accompany the paper when handed in, and the chairman shall decide whether the abstract only or the entire paper be presented to the meeting for its consideration and discussion. All papers shall be subject to the approval and revision of the Committee of Publication. No report or paper will be received by the Society in an incomplete or unfinished condition, and no paper shall be published as part of the Transactions which has been published previous to its presentation.

SEC. 2. Any paper may be published in a medical journal at any time subsequent to its presentation, provided that it be prepared in duplicate, and the original retained in the custody of the Committee on Publication.

SEC. 3. All communications read before the Society shall become its property; but no paper shall be published as part of the Transactions of the Society without its sanction.

SEC. 4. All discussions shall be strictly confined to the subject of the paper or report, and each speaker shall be limited to a speech of ten minutes, and to one of five minutes if he speaks a second time, and no excess of time shall be allowed except by consent of the Society. The reader of the paper shall be allowed ten minutes at the close of the discussion.

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SEC. 5. Each county or local society shall be invited to prepare and discuss, during the year, a paper upon some medical subject, and present it to the Society at its annual meeting, through its appropriate bureau.

ARTICLE VIII.—AMENDMENTS.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

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ORDER OF BUSINESS.

1. Calling the meeting to order.
2. Address by the President.
3. Roll-call and correction of list of members.
4. Appointment of Committee on President's Address.
5. Report of Treasurer.
6. Appointment of Auditing Committee.
7. Report of Corresponding Secretary.
8. Reports of committees.
9. Report of Censors and election of members.
10. Reports of Bureaus.
11. Unfinished business.
12. New business.
13. Election of officers.
14. Announcement of bureaus and committees.
15. Adjournment.

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LIST OF MEMBERS.

1885—Allen, John V., M.D., Frankford, Philadelphia.
1870—Allen, J. W., M.D., Altoona.
1883—Allen, Richard C., M.D., 4519 Frankford Ave., Phila.
1885—Arthur, Charles, M.D., Richfield, Kansas.
1883—Baker, Alfred E., M.D., Norwynden Farm, West Chester.
1885—Baker, C. H., M.D., 34 N. 40th Street, Philadelphia.
1881—Bartlett, Clarence, M.D., 1506 Girard Ave., Phila.
1885—Berkenstock, W. F., M.D., 1919 Girard Ave., Phila.
1875—Betts, B. F., M.D., 1609 Girard Ave., Philadelphia.
1886—Bier, P. A., M.D., 4400 Butler Street, Pittsburgh.
1872—Bigler, W. H., M.D., 118 N. 12th Street, Philadelphia.
1873—Bingaman, C. F., M.D., 922 Penn Ave., Pittsburgh.
1886—Bonnet, Gustav E., M.D., 636 N. 11th Street, Phila.
1872—Bowie, A. P., M.D., Uniontown.
1884—Boyd, G. S., M.D., Beaver Falls.
1880—Boyd, J. S., M.D., New Brighton.
1882—Boyer, Francis W., M.D., Pottsville.
1875—Bradford, L. J., M.D., Sylvania.
1883—Branson, Mary, M.D., 1719 Arch Street, Philadelphia.
1872—Brickley, Obadiah C., M.D., York.
1887—Briggs, E. E., M.D., Washington Ave , Pittsburgh.
1887—Briggs, H. G., M.D., 10 Washington Ave., Pittsburgh.
1881—Brooks, Charles M., M.D., 1613 N. 10th Street, Phila.
1883—Brown, Samuel, M.D., 651 N. 10th Street, Phila.
1879—Buck, M. J., M.D., Altoona.
1885—Buchman, Frank, M.D., 1410 S. 5th Street, Phila.
1886—Bulick, T. M., M.D., Altoona.
1877—Bullard, J. A., M.D., Wilkes-Barre.
1881—Bunting, H. M., M.D., Norristown.
1888—Burchfield, S. E., M.D., Tarentum.

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1866—Burgher, J. C., M.D., 960 Penn Ave., Pittsburgh.
1868—Carmany, C. J., M.D., Harrisburg.
1888—Carmichael, T. H., M.D., Germantown, Philadelphia.
1873—Chantler, I. B., M.D., Sewickley.
1875—Chapman, Millie J., M.D., 916 Penn Ave., Pittsburgh.
1866—Childs, W. R., M.D., 934 Penn Avenue, Pittsburgh.
1888—Chisolm, H. C., M.D., Harrisburg.
1885—Christine, G. Maxwell, M.D., 2043 N. 12th St., Phila.
1886—Closson, J. H., M.D., 72 W. Chelten Ave., Gtn., Phila.
1883—Coe, Sarah J., M.D., Wilkes-Barre.
1873—Cook, I. Elmer, M.D., Harrisburg.
1887—Cooper, John, M.D., 42 N. Diamond St., Allegheny.
1866—Cooper, J. F., M.D., 105 Arch Street, Allegheny.
1887—Cowley, William, M.D., 6442 Penn Ave., Pittsburgh.
1882—Cranch, Edward, M.D., Erie.
1875—Crawford, J. S., M.D., Greensburg.
1883—Crowther, Isaac, M.D., Chester.
1887—Crumpton, Margaret L., M.D., 26 Sherman Avenue, Allegheny.
1883—Davis, E. Everett, M.D., 4224 Brown Street, Phila.
1882—Dean, E. W., M.D., Braddock.
1885—Deardorff, J. H., M.D., Mechanicsburg.
1866—Detwiller, John J., M.D., Easton.
1879—Detwiller, J. W., M.D., Bethlehem.
1886—Dietz, W. G., M.D., Hazelton.
1878—Dinsmore, S. W. S., M.D., Sharpsburg.
1880—Doolittle, E. D., M.D., Easton.
1867—Dudley, Pemberton, M.D., 15th and Master Sts., Phila.
1878—Duff, P. S., M.D., Great Belt.
1882—Du Four, W. M., M.D., Williamsport.
1875—Dunn, James L., M.D., Titusville.
1881—Dunning, T. S., M.D., 1328 N. 15th Street, Phila.
1870—Earhart, J. R., M.D., 1904 Arch Street, Philadelphia.
1873—Edmundson, W. F., M.D., 375 Fifth Ave., Pittsburgh.
1882—Evans, H. J., M.D., Altoona.
1880—Ferson, J. L., M.D., 137 Wylie Avenue, Pittsburgh.
1884—Fleming, R. K., M.D., 6217 Station Street, Pittsburgh.
1883—Fornias, Eduardo, M.D., 327 Pine Street, Philadelphia.

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1873—Fulton, H. W., M.D., 5949 Penn Avenue, Pittsburgh.
1867—Garvin, John J., M.D., 1546 N. 11th Street, Phila.
1866—Gause, Owen B., M.D., Aiken, S. C.
1886—Gerhart, Joseph M., M.D., 603 N. 12th Street, Phila.
1870—Gessler, C. W., M.D., 1332 S. 5th Street, Philadelphia.
1879—Getze, G. M., M.D , Tarentum.
1885—Giles, J. William, M.D., 1930 Chestnut Street, Phila.
1875—Goodno, W. C., M.D., 4003 Chestnut Street, Phila.
1875—Graham, D. M., M.D., Chicago, Ill.
1883—Gramm, E. M., M.D., 934 N. 6th Street, Philadelphia.
1867—Gramm, G. E., M.D., Gwynedd, Montgomery Co.,
1883—Gramm, Theo. J., M.D., 1409 Hanover Street, Phila.
1886—Griffith, J. J., M.D., Manayunk, Philadelphia.
1888—Griffith, Lewis B., M.D., 2514 Ridge Ave., Phila.
1881—Griffith, Silas, M.D., 1431 Girard Ave., Philadelphia.
1877—Griffith, W. M., M.D., 2035 Ridge Ave., Philadelphia.
1886—Grimes, Thomas H., M.D., Sewickley.
1888—Gross, F. O., M.D., 1808 N. 8th Street, Philadelphia.
1874—Guernsey, J. C., M.D., 1923 Chestnut Street, Phila.
1867—Gumpert, B. Barton, M.D., 840 Franklin Street, Phila.
1886—Gundlach, F. C., M.D., 56 S. 18th Street, Pittsburgh.
1885—Haines, O. S., M.D., 137 N. 15th, Philadelphia.
1879—Hall, William D., M.D., Altoona.
1887—Haman, W. A., M.D., Reading.
1883—Hancock, Joseph, M.D., 1639 Columbia Avenue, Phila.
1888—Harner, John E., M.D., Honeybrook.
1884—Harris, D. R., M.D., New Castle.
1883—Hassler, W. A., M.D., Allentown.
1881—Hawley, Annie M., M.D., Pughtown.
1888—Hawley, L. B., M.D., Phœnixville.
1883—Helfrich, J. H., M.D., Allentown.
1873—Herron, C. D., M.D., Butler Street, Pittsburgh.
1882—Hofmann, C. H., M.D., 808 Penn Avenue, Pittsburgh.
1866—Hofmann, H. H., M.D., 808 Penn Avenue, Pittsburgh.
1883—Holben, M. J., M.D., Slatington.
1887—Holcombe, J. R., M.D., 1323 Girard Avenue, Phila.
1883—Horner, J. Richey, M.D., 107 Arch Street, Allegheny.
1880—Humes, J. R., M D., Hollidaysburg.
1886—Ingersoll, W. K., M.D., 4008 Chestnut Street, Phila.

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1882—Ivins, Horace F., M.D., 1319 Arch Street, Phila.
1883—Jackson, Lora C., M.D., 1526 Arch Street, Phila.
1888—Jackson, W. H., M.D., Oil City.
1866—James, Bushrod W., M.D., 18th and Green Sts., Phila.
1885—James, Horace E., M.D., 1229 S. 8th Street, Phila.
1867—James, John E., M.D., 1521 Arch Street, Philadelphia.
1870—James, Walter M., M.D., 1123 Spruce Street, Phila.
1888—Jennings, C. B., M.D., Reading.
1877—Johnson, Maria N., M.D., 1732 Green Street, Phila.
1881—Johnson, Theodore M., M.D., Pittston.
1869—Jones, Joseph E., M.D., West Chester.
1881—Karsner, Daniel, M.D., 4830 Main Street, Germantown.
1885—Keim, William H., M.D., 2015 Ridge Avenue, Phila.
1875—Kern, W. H., M.D., McKeesport.
1884—King, W. D., M.D., 328 Fifth Avenue, Pittsburgh.
1887—Kistler, H. E., M.D., 2501 Jefferson Street, Phila.
1877—Knerr, C. B., M.D., N.E. cor. 12th and Spruce Sts., Phila.
1873—Koenig, M. J., M.D., Jersey Shore.
1872—Korndœrfer, Aug., M.D., 1728 Green Street, Phila.
1888—Layman, Alfred, M.D., 1628 N. 18th Street, Phila.
1887—Leake, E. N., M.D., Butler.
1884—Lee, Charles H., M.D., New Castle.
1879—Lee, John K., M.D., Johnstown.
1873—Lefever, Isaac, M.D., Harrisburg.
1866—Liscomb, P. D., M.D., Beaver Falls.
1868—Macfarlan, Malcolm, M.D., 1805 Chestnut St., Phila.
1886—Maddux, D. P., M.D., Chester.
1883—Maguire, W. T., M.D., Darby.
1866—Malin, John, M.D., 70 W. Chelten Ave., Germantown.
1877—Malin, William H., M.D., Chestnut Hill, Philadelphia.
1881—Mansfield, J. R., M.D., 4852 Main Street, Germantown.
1886—Marks, W. F., M.D., Reading.
1885—Marsden, Biddle R., M.D., Chestnut Hill, Philadelphia.
1883—Marshall, Anna M., M.D., 1608 Mt. Vernon St., Phila.
1866—Martin, H. N., M.D., 1218 Walnut Street, Phila.
1877—Martin, W. J., M.D., 1712 Carson St., S. S., Pittsburgh.
1878—Maurer, J. M., M.D., Washington.
1881—May, Newton, M.D., Holmesburg.

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1881—Mercer, Robert P., M.D., Chester.
1888—Mercer, E. W., M.D., 157 N. 15th, Philadelphia.
1888—Mercer, C. S., M.D., Media.
1888—Merriam, Franklin E., M.D., 2101 Franklin St., Phila.
1888—Messerve, F. W., M.D., 220 Franklin Street, Phila.
1871—Middleton, Caleb S., M.D., 1521 Girard Ave., Phila.
1887—Millen, J. C., M.D., 1939 N. 18th Street, Philadelphia.
1877—Miller, Z. T., M.D., 2013 Carson St., S. S., Pittsburgh.
1883—Mitchell, J. N., M.D., 1222 Walnut Street, Phila.
1875—Mohr, Charles, M.D., 555 N. 16th Street, Phila.
1867—Morgan, John C., M.D., 110 S. 17th Street, Philadelphia.
1881—Mullen, S. A., M.D., West Chester.
1883—Mullin, W. P., M.D., 5007 Green Street, Germantown.
1888—Murdock, Robert, M.D., Wilkes-Barre.
1879—McClelland, J. B., M.D., 411 Penn Avenue, Pittsburgh.
1867—McClelland, J. H., M.D., 411 Penn Avenue, Pittsburgh.
1884—McClelland, R. W., M.D., 411 Penn Avenue, Pittsburgh.
1883—McClure, Eliza H. Lang, M.D., 1919 Wallace St., Phila.
1888—McDowell, Charles H., M.D., Shackamaxon St., Phila.
1866—Neville, W. H. H., M.D., 19th and Wallace Sts., Phila.
1886—Oatley, E. L., M.D., 4003 Chestnut Street, Phila.
1887—Page, Henry A., M.D., Pittsburgh.
1884—Parker, G. W., M.D., 1404 S. 6th Street, Philadelphia.
1883—Parker, T. Ellwood, M.D., Claremont, N. H.
1870—Parsons, Anson, M.D., Springboro.
1881—Parsons, E. C., M.D., Meadville.
1880—Peach, William, M.D., Monterey St., Allegheny City.
1885—Peacock, William, M.D., 2217 N. 6th Street, Phila.
1881—Perkins, C. W., M.D., Chester.
1883—Pettingill, Eliza F., M.D., 300 N. 10th Street, Phila.
1870—Pierce, W. A. D., M.D., 2004 Mt. Vernon St., Phila.
1880—Pitcairn, Hugh, M.D., Harrisburg.
1886—Posey, L. P., M.D., 1132 Arch Street, Philadelphia.
1883—Powell, W. C., Jr., M.D., Bryn Mawr.
1881—Pratt, J. W., M.D., Coatesville.
1871—Pratt, Trimble, M.D., Media.
1866—Preston, Mahlon, M.D., Norristown.
1875—Ramage, R. Y., M.D., Mansfield Valley.

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1872—Rankin, J. S., M.D., 59 Grant Street, Pittsburgh.
1866—Raue, Charles G., M.D., 121 N. 10th Street, Phila.
1867—Reading, E., M.D., Hatboro.
1883—Reading, J. H., M.D., 1811 Green Street, Philadelphia.
1886—Reading, L. W., M.D., 1519 Arch Street, Philadelphia.
1888—Reading, Thomas, M.D., Homœopathic Hospital, Pittsburgh.
1886—Reeves, Jos. M., M.D., 1609 Mt. Vernon St., Phila.
1878—Rinehart, C. C., M.D., Marion Station, Pittsburgh.
1871—Rittenhouse, S. R., M.D., Reading.
1880—Robson, J. W., M.D., Marion Station, Pittsburgh.
1887—Rodes, Jos., M.D., 252 N. 20th Street, Philadelphia.
1873—Roseberry, C. I., M.D., Easton
1883—Ross, S. C., M.D., Scranton.
1883—Rousseau, L. G., M.D., 408 Penn Avenue, Pittsburgh.
1872—Rutter, J. C., M.D., Bloomsburg.
1888—Sands, J. H., M.D., Plymouth.
1872—Sartain, Harriet J., M.D., 212 W. Logan Sq., Phila.
1874—Schmucker, F. R., M.D., Reading.
1883—Schreiner, Emma T., M.D., Germantown, Philadelphia.
1880—Scott, S. C., M.D., Pittsburgh.
1886—Seibert, W. A., M.D., Easton.
1868—Seip, C. P., M.D., 636 Penn Avenue, Pittsburgh.
1875—Shannon, O. R., M.D., 207 Lacock Street, Allegheny.
1879—Shannon, S. F., M.D., Sewickley.
1883—Sharkey, W. P., M.D., 1938 Girard Ave., Philadelphia.
1888—Sharpless, E. S., M.D., N.E. cor. 11th and Ogden Sts., Philadelphia.
1885—Shellenberger, C. N., M.D., 1831 Wallace St., Phila.
1883—Shemp, P. D., M.D., Philadelphia.
1883—Skeels, J. S., M.D., Albion.
1883—Slough, F. J., M.D., Allentown.
1883—Slough, W. C. J., M.D., Emaus.
1880—Smedley, I. G., M.D., 1705 Arch Street, Philadelphia.
1887—Smith, Mary E., M D., 51 E. Diamond, Allegheny.
1887—Snader, E. R., M.D., 140 N. 20th Street, Philadelphia.
1887—Speakman, W. W., M.D., 914 N. Broad Street, Phila.
1870—Spencer, J. H., M.D., 1306 N. 7th Street, Philadelphia.

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1883—Starr, Samuel, M.D., Chester.
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1883—Still, Horace, M.D., Norristown.
1885—Strong, J. Wilmer, M.D., 2049 N. 13th Street, Phila.
1888—Sullivan, J. Bailey, M.D., Allegheny.
1881—Swartz, J. R., M.D., Harrisburg.
1881—Thatcher, J. W., M.D., 35th and Hamilton Sts., Phila.
1871—Thomas, A. R., M.D., 113 S. 16th Street, Phila.
1877—Thomas, Charles Monroe, M.D., 1623 Arch St., Phila.
1886—Tindall, Van R., M.D., 240 Federal Street, Phila.
1886—Thompson, J. H., M.D., 960 Penn Ave., Pittsburgh.
1887—Thompson, Landreth W., M.D., 1031 Green St., Phila.
1881—Tomlinson, W. H., M.D., 5210 Main St., Germantown.
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1883—Van Deusen, Josephine, M.D., 21st & Tioga Sts., Phila.
1881—Van Lennep, W. B., M.D., 1421 Spruce St., Phila.
1867—Walker, Mahlon M., M.D., 12 W. Walnut Lane, Germantown, Philadelphia.
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1883—Weaver, W. P., M.D., Bristol.
1870—White, N., M.D., New Castle.
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1866—Willard, L. H., M.D., Western Ave., Allegheny City.
1881—Williams, H. E., M.D., Coatesville.
1866—Williams, Thomas C., M.D., 567 N. 5th Street, Phila.
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1883—Wood, H. C., M.D., West Chester.
1866—Wood, James B., M.D., West Chester.
1883—Yearsley, William, M.D., 1532 N. 13th Street, Phila.
1888—Yocum, C. A., M.D., Pottstown.
1880—Yoder, D., M.D., Catasauqua.
1874—Young, J. H., M.D., 1630 Green Street, Philadelphia.

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1873—Nichol, Thomas, M.D., Montreal, Canada.
1873—Pope, Alfred C., M.D., London, England.

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1866—Ashton, A. H., M.D., died February 18th, 1883.
1866—Barnaby, John E., M.D., died January 5th, 1869.
1867—Barrett, Charles B., M.D., died June 5th, 1871.
1882—Bernard, H., M.D., died ———
1866—Blakely, W. James, M.D., died January 14th, 1877.
1870—Bratt, Benjamin R., M.D., died January 31st, 1872.
1866—Brooks, Silas S., M.D., died July 2d, 1871.
1883—Burr, Richard, M.D., died March 30th, 1885.
1873—Caruthers, R. E., M.D., died January 3d, 1885.
1868—Charlton, S. T., M.D., died November 9th, 1886.
1866—Cooke, William H., M.D., died March 21st, 1879.
1866—Cote, M., M.D., died May 29th, 1878.
1866—Cowley, David, M.D., died October 30th, 1886.
1866—Detweiler, Henry, M.D., died April 21st, 1887.
1871—Dreibelbis, David L., M.D., died March 24th, 1872.
1870—Farrington, E. A., M.D., died December 17th, 1885.
1866—Friese, Michael, M.D., died February 4th, 1880.
1866—Frost, J. H. P., M.D., died January 21st, 1875.
1866—Gardiner, Richard, M.D., died March 22d, 1877.
1883—Gause, Percival O. B., M.D., died November 10th, 1887.
1877—Grumbein, William, M.D., died ———
1866—Guernsey, H. N., M.D., died June 27th, 1885.
1870—Guernsey, W. F., M.D., died February 16th, 1877.
1866—Herron, James A., M.D., died November 15th, 1868.
1884—Hosfeld, George, M.D., died November 9th, 1884.
1873—Houard, J. G., M.D., died April 24th, 1878.
1866—James, David, M.D., died June 6th, 1873.
1886—Jeanes, Jacob, M.D., died December 18th, 1877.
1866—Koch, Augustus W., M.D., died May 4th, 1886.
1866—Lee, J. K., M.D., died November 10th, 1887.

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1867—Lippe, Adolph, M.D., died January 23d, 1888.
1871—Lovejoy, E., M.D. (honorary), died August 15th, 1872.
1868—Malin, George W., M.D., died January 18th, 1883.
1866—Marsden, J. H., M.D., died August 27th, 1883.
1866—McClatchey, R. J., M.D., died January 15th, 1883.
1870—Moore, Thomas, M.D., died March 25th, 1882.
1869—Ostrander, W. M., M.D., died August 23d, 1881.
1868—Payne, Wm. E., M.D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M.D. (corresponding), died April 18th, 1881.
1868—Pfoutz, J. S., M.D., died ———
1866—Preston, Coates, M.D., died August 9th, 1881.
1868—Pulte, J. H., M.D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M.D., died March 15th, 1885.
1866—Reading, John R., M.D., died February 14th, 1886.
1870—Reinhold, H. E., M.D., died March 6th, 1879.
1866—Roberts, R. Ross, M.D., died April 4th, 1875.
1866—Rosseau, L. M., M.D., died September 25th, 1882.
1872—Scott, James L., M.D., died August 15th, 1876.
1872—Speth, W. F., M.D., died May 11th, 1881.
———Stauffer, D. R., M.D., died March 16th, 1874.
1867—Stevens, C. A., M.D., died January 17th, 1881.
1870—Taudte, F., M.D., died March 27th, 1878.
1880—Way, J. H., M.D., died September 3d, 1887.
1866—Williamson, Walter, M.D., died December 19th, 1870.
1866—Williamson, Walter M., M.D., died May 5th, 1874.
1880—Zerns, William M., M.D., died September 21st, 1887.

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INDEX.

PAGE

Address of Welcome, ... 9
Address, President's Annual, ... 10
Allegheny County Society, Hay Fever, by the, ... 85
Anatomical Lesions in Inveterate Intermittent Fever. J. C. Morgan, M.D., . 227
Arsenicum Album. By the Farrington Club, ... 117
" " Abdomen and Hypochondria. Charles Gangloff, M.D., 155
" " Aggravations and Ameliorations, ... 205
" " Ear Symptoms. R. K. Fleming, M.D., ... 133
" " Effects of Arsenicum on the Heart. Z. T. Miller, M.D., 181
" " Eye Symptoms. R. K. Fleming, M.D., ... 131
" " Fauces, Pharynx and Œsophagus. J. L. Ferson, M.D., 150
" " Female Genital Organs. J. Richey Horner, M.D , . 176
" " General Analysis. J. Richey Horner, M.D., . . . 127
" " Mental Symptoms. Z. T. Miller, M.D., ... 119
" " Mouth. Z. T. Miller, M.D., ... 139
" " Neck, Back and Limbs. R. K. Fleming, M.D , . . 196
" " Nerves. W. J. Martin, M.D., ... 189
" " Respiratory Organs. W. D. King, M.D., ... 179
" " Skin Symptoms. J. Bailey Sullivan, M.D., ... 198
" " Sleep. W. J. Martin, M.D., ... 195
" " Stool and Anus. J. H. Thompson, M.D., ... 169
" " Symptoms of the Head and Face. J. Richey Horner, M.D., ... 127
" " Symptoms of the Respiratory Organs. J. H. Thompson, M.D., ... 185
" " Teeth. Z. T. Miller, M.D., ... 132
" " Urinary Organs. W. J. Martin, M.D., ... 172
Auditing Committee, Report of the, ... 25

Baby Therapeutics. Z. T. Miller, M.D., ... 341
Balsam of Copaiva: An Experiment. E. Cranch, M.D., ... 341
BARTLETT, CLARENCE, M.D. Discussion by, ... 96, 273
BETTS, B. F., M.D. Influence of Gonorrhœal Infection on the Development of Pelvic Disease in Women, ... 222
BIGLER, W. H., M.D. Errors of Refraction and the Use and Abuse of Spectacles, ... 65
BULICK, T. M., M.D. Cervical Endometritis, ... 216
Bureaus and Committees, Appointment of, ... 366
BURGHER, J. C., M.D., Hay-fever, ... 86

Digitized by Google

PAGE
Calling to Order, ... 9
Case of Carcinoma of the Breast *v.* Erysipelas and Arsenic. Chas. Mohr, M.D., 288
Case of Pulmonary Tuberculosis, and the Effects of One Dose of Calcarea Carb., 50,000. W. J. Martin, M.D., ... 310
Censors, Report of the, ... 34
Cervical Endometritis. T. M. Bulick, M.D., ... 216
CHAPMAN, MILLIE J., M.D. Erosion of the Os Uteri, ... 213
Character of the Pulse after Labor. J. M. Reeves, M.D., ... 98
CHILDS, W. R., M.D. Surgical Cases, ... 342
Chorea. S. F. Shannon, M.D., ... 37
CHRISTINE, G. MAXWELL, M.D. Some General Remarks on Blood-letting, 298
Chronic Gastric Catarrh. E. C. Parsons, M.D., ... 273
Clinical Cases. Sarah J. Coe, M.D., ... 267
" " William A. Haman, M.D., ... 260
CLOSSON, J. H., M.D. Tinea Tonsurans, ... 48
COE, SARAH J., M.D. Clinical Cases, ... 267
Committee on President's Address, Appointment of, ... 25
" " " Report of, ... 365
" on Publication, Report of, ... 27
Constipation in Infants. J. Richey Horner, M.D., ... 43
Constitution and By-Laws, ... 369
Corresponding Secretary, Report of the, ... 26
CROWTHER, ISAAC, M.D. Discussion by, ... 97
CRUMPTON, MARGARET L., M.D. Polio-myelitis Anterior Acuta, . . . 35

DUDLEY, PEMBERTON, M.D. The Sanitary System of Pennsylvania; Its Merits and Defects, ... 59

Effects of Tobacco on the Heart. E. R. Snader, M.D., ... 251
Erosions of the Os Uteri. Millie J. Chapman, M.D., ... 213
Errors of Refraction and the Use and Abuse of Spectacles. W. H. Bigler, M.D., ... 65

Farrington Club. Arsenicum Album, ... 117
FERSON, JOHN L., M.D. Action of Arsenicum on the Throat, Pharynx and Œsophagus, ... 150
FLEMING, R. K., M.D. Ear Symptoms of Arsenicum, ... 133
" " Eye Symptoms of Arsenicum, ... 131
" " Action of Arsenicum on the Neck, Back and Limbs, 196
Foreign Bodies in the Ear and their Extraction. Joseph E. Jones, M.D., . 71

GANGLOFF, CHARLES, M.D. Surgical Cases, ... 359
" " Action of Arsenicum on the Abdomen and Hypochondria, ... 155
GAUSE, PERCY O. B., M.D. Obituary of, ... 32
General Business, ... 362

Digitized by Google

PAGE
GOODNO, W. C., M.D. Phthisis Pulmonalis, ... 313
GRAMM, E. M., M.D. Discussion by, ... 271
GRIFFITH, J. J., M.D. Discussion by, ... 95
GUERNSEY, J. C., M.D. Discussion by, ... 112

HAMAN, WILLIAM A. Clinical Cases, ... 260
HAWLEY, L. B., M.D. Discussion by, ... 309
Hay-Fever. The Allegheny County Society, ... 85
HORNER, J. RICHEY, M.D. Constipation in Infants, ... 43
" " Action of Arsenicum on the Female Genitals, . 176
" " Head and Face Symptoms of Arsenicum, . 127
" " General Symptoms of Arsenicum, . . . 117

Infants, Constipation in. J. Richey Horner, M.D., ... 45
Influence of Gonorrhœal Infection on the Development of Pelvic Diseases in Women. B. F. Betts, M.D., ... 222
INGERSOLL, W. K., M.D. Neoplasms and their Genesis, ... 237
" " Discussion by, ... 267
IVINS, HORACE F., M.D. Three Cases of Papillomata of the Larynx, . 78

JAMES, B. W., M.D. Discussion by, ... 323
JAMES, JOHN E., M.D. Discussion by, ... 357
JONES, JOS E., M.D. Foreign Bodies in the Ear, and their Extraction, . 71
" " Discussion by, ... 94, 359

KING, W. D., M.D. Effects of Arsenic on the Respiratory Organs, . . 179

LEE, J. K., M.D. Obituary of, ... 30
LEE, J. K., M.D., of Johnstown. Discussion by, ... 113, 324
LIPPE. Obituary of Adolph, M.D., ... 32
List of Members, ... 377

MADDUX, D. P., M.D. Discussion by, ... 323
MALIN, JOHN, M.D. Discussion by, ... 116
MARTIN, W. J. M.D. Action of Arsenicum on the Nerves, . . . 189
" " " " on Sleep, ... 195
" " " " on the Urinary Organs, . . 172
" " Prolapsus of the Umbilical Cord, ... 101
MILLER, Z. T., M.D. Baby Therapeutics, ... 333
" " Discussion by, ... 95, 116
" " Effects of Arsenicum on the Heart, ... 181
" " Mental Symptoms of Arsenicum, ... 119
" " Mouth Symptoms of Arsenicum, ... 139
" " Staphisagria for the Relief of Mercurial Eczema, . 331
" " Teeth Symptoms of Arsenicum, ... 133
" " Unsuccessful Clinical Experience, ... 292
MITCHELL, J. N., M.D. Discussion by, ... 109, 115, 116

Digitized by Google

PAGE

MOHR, CHARLES, M.D. A Case of Carcinoma of the Breast *v.* Erysipelas and Arsenic, ... 288
" " Discussion by, ... 115, 272, 321
" " Provings of Zincum Picricum, ... 206
MORGAN, J. C., M.D. Anatomical Lesions in Inveterate Intermittent Fever, 227
" " Discussion by, ... 114, 267, 272, 309

Necrological List, ... 385
Necrological Report, ... 30
Neoplasms and their Genesis. W. K. Ingersoll, M.D , ... 237
NEVILLE, W. H. H., M.D. Tinnitus Aurium, ... 90

Organization, Registration and Statistics, Report of the Bureau of, . . . 28

PARSONS, E. C., M.D. Chronic Gastric Catarrh, ... 273
Pathology of Renal Calculi. Joseph Rodes, M.D., ... 242
Pennsylvania, Sanitary System of, its Merits and Defects. Pemberton Dudley, M.D., ... 59
PITCAIRN, HUGH, M.D., President's Annual Address, ... 10
" " Discussion by, ... 96
Polio-myelitis Anterior Acuta. Margaret L. Crumpton, M.D., ... 35
President's Annual Address, ... 10
" " " Appointment of Committee on, ... 25
Prolapsus of the Umbilical Cord. W. J. Martin, M.D., ... 101
Provings of Zincum Picricum. Charles Mohr, M.D., ... 207
Pulmonary Phthisis. W. C. Goodno, M.D., ... 313

REEVES, JOSEPH M., M.D. Character of the Pulse after Labor, ... 98
Remarks on the Antiseptic Treatment of Carbuncle and Kindred Inflammations. W. B. Van Lennep, M.D., ... 346
Report of the Bureau of Clinical Medicine, ... 250
" " " Gynæcology, ... 213
" " " Materia Medica, ... 116
" " " Obstetrics, ... 97
" " " Ophthalmology, Otology and Laryngology, . . . 65
" " " Pathology, ... 227
" " " Pædology, ... 34
" " " Sanitary Science, ... 58
" " " Surgery, ... 341
" " " Organization, Registration and Statistics, . . . 28
" " Auditing Committee, ... 25
" " Committee on Publication, ... 27
" " Board of Censors, ... 34
" " Corresponding Secretary, ... 26
" " Treasurer, ... 25
RODES, JOSEPH, M.D. Pathology of Renal Calculi, ... 24

Digitized by Google

PAGE

Sanitary System of Pennsylvania; Its Merits and Defects. Pemberton Dudley, M.D., ... 59
SHANNON, S. F., M.D. Chorea, ... 37
SNADER, E. R., M.D. Discussion by, ... 323
" " Effects of Tobacco on the Heart, ... 251
" " Suggestions Concerning the Auxiliary Treatment of Simple Cardiac Hypertrophy, ... 282
Some General Remarks on Blood-Letting. G. Maxwell Christine, M.D., . 298
Staphisagria for the Relief of Mercurial Eczema. Z. T. Miller, M.D., . 331
Suggestions Concerning the Auxiliary Treatment of Simple Cardiac Hypertrophy. E R. Snader, M.D., ... 282
SULLIVAN, J. BAILEY, M.D. Skin Symptoms of Arsenicum, ... 198
Surgical Cases. W. R. Childs, M.D., ... 342
" " Charles Gangloff, M.D., ... 359

THATCHER, J. W., M.D. Vaginismus, ... 219
THOMAS, C. M., M.D. Discussion by, ... 365
THOMPSON, J. H., M.D. Stool and Anus Symptoms of Arsenicum, . . 169
" " Respiratory Symptoms of Arsenicum, . . . 185
Three Cases of Papillomata of the Larynx. Horace F. Ivins, M.D., . . 78
Tinea Tonsurans. J. H. Closson, M.D., ... 48
Tinnitus Aurium. W. H. H. Neville, M.D., ... 90
Treasurer, Report of the, ... 25
TRITES, W. B., M.D. Why Early Homœopathy was Successful in the Treatment of Syphilis, ... 325
" " Discussion by, ... 273

Unsuccessful Clinical Experience. Z. T. Miller, M.D., ... 292

Vaginismus. J. W. Thatcher, M.D., ... 219
Van Lennep, W. B., M.D. Discussion by, ... 358
" " Remarks on the Antiseptic Treatment of Carbuncle and Kindred Inflammations, . . 346

WALKER, M. M., M.D. Discussion by, ... 97, 273
WEAVER, CHANDLER, M.D. Discussion by, ... 96
Why Early Homœopathy was Successful in the Treatment of Syphilis. W. B. Trites, M.D., ... 325
WILLARD, L. H., M.D. Discussion by, ... 353
WINSLOW, W. H., M.D. Hay-Fever, ... 88

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